Developing a Scale for Assessing the Forensic Experience of Recovery: the SAFER questionnaire and Clinical Research Portfolio

Volume I

(Volume II bound separately)

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Contents

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Chapter 1: Systematic Review

Evidence for the effectiveness of the Good Lives Model in reducing recidivism and factors necessary to implement interventions based on the model: A Systematic Review.

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Abstract

Background: The Good Lives Model (GLM) is a strength-based approach to offender rehabilitation which aims to promote psychological wellbeing and reduce recidivism. Interventions based on the model incorporate values and personally salient goals. There is limited research on the effectiveness of the GLM. **Aims:** a) to review the evidence for the effectiveness of the GLM in reducing recidivism compared to other approaches, b) to explore any additional benefits when utilised as part of a wider rehabilitation programme and c) to consider the factors necessary to implement the model. **Method:** Guidance from the Non-Randomised Studies Methods Group of The Cochrane Collaboration was consulted to evaluate risk of bias. The Structured Assessment of Feasibility Evaluation tool was used to review studies relevant to the implementation of the GLM. **Results:** Systematic search of online databases and hand searches of selected texts identified twenty-six potential studies. Using specified inclusion criteria this was reduced to eleven studies. Four quantitative studies were identified to answer the first two research questions. They were not randomised, did not have parallel control trials and were retrospective. Two studies used routinely collected data and two used a coding protocol to review files to evaluate release planning. One study showed no difference between the GLM and relapse prevention in terms of changes on outcome measures. One study showed a tentative link between GLM and recidivism. There was significant risk of bias in the studies. Seven studies exploring implementation of the GLM identified significant gaps in the literature e.g. lack of transparency in relation to resource implications and not based on treatment manuals. **Conclusions:** There was no robust evidence that interventions based on the GLM were effective in reducing recidivism. The review highlighted the need for more robust research, a need to investigate the process of implementation and the development of a competency framework.

Keywords: Good Lives Model, Recidivism

Introduction

The Good Lives Model (GLM) is a strength-based approach to offender rehabilitation which aims to promote psychological wellbeing and reduce recidivism (Fortune, Ward & Polaschek, 2014; Whitehead, Ward & Collie, 2007). The GLM draws on psychological, social, biological and anthropological research and is based on the premise that everyone aims to construct a sense of purpose in their lives (Willis & Ward, 2013). The GLM proposes that this is achieved through the pursuit of 'primary goods', which are internal and external experiences sought for their own sake, reflective of values and related to psychological wellbeing (Ward, Mann & Gannon, 2007). Primary goods include – Life, knowledge, excellence in play and work, autonomy, inner peace, relatedness, spirituality, happiness and creativity (Ward & Brown, 2004). Secondary goods are the means by which primary goods are pursued (Ward et al., 2007). The GLM indicates that offenders have the same basic human needs as everyone else and that offending occurs when someone lacks the capacity, resources and opportunities to achieve primary goods or relies on inappropriate means of securing goods (Whitehead et al., 2007).

The GLM is intended to be a holistic, flexible approach which takes into account individuals' preferences and values and treatment is based on personally salient goals (Ward & Brown, 2004). As part of assessment a good lives plan is developed collaboratively to identify value placed on primary goods and identify pro-social, approach-focused, treatment goals (Ward & Fortune, 2013). Individuals are supported to obtain relevant resources and develop necessary skills to achieve goals in a socially appropriate manner (Ward & Brown, 2004). Internal resources include attitudes, beliefs, knowledge and skills, while external resources include social support, intimate relationships, education/training, employment and leisure activities (Fortune et al., 2012).

Prior to the development of the GLM, the Risk Need Responsivity (RNR) Model (Andrew & Bonta, 2003) dominated in the field of offender rehabilitation. It is based on three

principles. The risk principle relates to matching intensity of intervention with level of risk. The need principle indicates that treatment should target specific criminogenic needs or dynamic risk factors. The responsivity principle indicates that treatment should be appropriately adapted to an individual's characteristics, cognitive ability and learning style. Meta analysis has shown that the RNR approach is effective in reducing sexual recidivism (Hanson, Bourgon, Helmus, & Hodgson, 2009). It tends to be operationalised through relapse prevention programmes and utilises cognitive behaviour interventions (Barnett & Wood, 2008). It focuses on offenders' deficits and aims to modify dynamic risk factors through avoidance goals (Willis & Grace, 2008). The main difficulties with the approach are poor motivation to engage and high attrition rates (Willis & Ward, 2013).

The GLM was not designed to replace the RNR model and should incorporate its principles as neglect of RNR principles could be counterproductive e.g. lead to higher recidivism rates (Willis, Ward & Levenson, 2014). The GLM aims to enhance the RNR model through the dual aims of risk management and wellbeing promotion (Willis et al., 2014). It has been proposed that the GLM can enhance motivation through its focus on values, strengths and approach-focused goals (Barnett, Manderville-Norden & Rakestrow, 2014). There has been preliminary evidence to indicate that the GLM can enhance efficacy of RNR based relapse prevention programmes (Willis et al., 2014). There has been research to indicate that offenders endorse the model and find GLM primary goods personally relevant (Willis & Ward, 2011). One study found that offenders reported difficulty prioritising primary goods, lacked capacity and means to appropriately secure goods and experienced conflict in the acquisition of goods at the time of their offending (Barnett & Wood, 2008).

The GLM was developed in relation to sexual offending (Willis & Ward, 2011) and has been used in prison and community settings. It has been used less in psychiatric settings and there has been limited research into its utility with mentally disordered offenders

(Gannon, King, Miles, Lockerbie & Willis, 2011). It has been proposed that the GLM can be applied within forensic mental health with adaptations to account for ways in which mental illness can interfere with primary goods acquisition due to internal and external limitations e.g. cognitive, psychological and social skills deficits, social isolation, stigma and lack of opportunity (Barnao, Robertson & Ward, 2010). Despite limited evidence, some psychiatric settings in the UK are using the GLM in their clinical practice (Gannon et al., 2011).

Rationale for systematic review: Within the substantial body of literature the majority of publications are theoretical. While GLM supporters advocate for its utility in relation to the effective rehabilitation of offenders, there are a limited number of empirical studies detailing its effectiveness. Studies tend to make tentative links between recidivism and primary goods rather than directly evaluating treatment based on the model. There is even less evidence for its effectiveness with mentally disordered offenders yet there is growing support for the model in forensic practice. The theory underpinning the model is in keeping with the current priorities of the health service i.e. recovery focused services which adopt strength-based, holistic and individualised interventions (Wallcraft, Tew, Griffiths & Nicholls, 2007). The health service also places considerable importance on the necessity of evidence-based interventions (Department of Health, 2011; NHS Education for Scotland & the Scottish Government, 2011). Some authors have argued that the GLM should not be incorporated into programmes of offender rehabilitation due to a lack of robust evidence (Ogloff & Davis, 2004). There is contradiction within the literature in terms of how the model is described by its developers. On one hand they propose that it is not intended as a specific treatment model but instead aims to provide a comprehensive framework of offender rehabilitation (Ward & Maruna, 2007) and specific evidenced-based interventions such as CBT are required as part of rehabilitation programmes (Willis & Ward, 2014). Despite this they also present the GLM as well researched and evidence-based and offer training and consultation to services that wish to implement the model

(http://www.goodlivesmodel.com). Furthermore, they refer to it as a comprehensive and systematic approach to the rehabilitation and therapeutic intervention of sexual offenders (Ward et al., 2007). It has been reported that the model can be implemented as an individually tailored treatment to target criminogenic needs (Willis & Ward, 2011). Despite the limited research carried out, it is claimed that the model can enhance the efficacy of offender rehabilitation programmes (Willis et al, 2014). One paper goes so far as to suggest that the fact that there is no evidence to the contrary, indicates that the attainment of primary goods is associated with reduced recidivism (Willis & Ward, 2011).

There has been one review which explored the effectiveness of the GLM in reducing recidivism (Netto, Carter & Bonell, 2014). This review differs from the one completed by Netto and colleagues because it has less stringent inclusion criteria and because it not only explores evidence for the GLM but also the feasibility of implementing the model. The current review was conducted to highlight gaps in the research with the aim of encouraging further research into the model.

Aims: The study aimed to explore the effectiveness of the GLM of offender rehabilitation and explore the feasibility of implementing the model.

Research questions

1) What is the evidence for the effectiveness of the GLM in reducing recidivism compared to any other control?
2) Are there any additional benefits when the GLM is utilised as part of a wider rehabilitation programme?
3) What are the necessary factors for implementing the GLM?

Methods

Protocol: The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analysis; Moher, Liberati, Tetzlaff, & Altman, 2009) checklist was used to structure this review.

Eligibility criteria: The inclusion criteria for questions one and two were: a) empirical studies evaluating GLM, b) published in peer reviewed journals, c) offenders in hospital, prison or community settings, d) compared to any control group (Q1), e) uncontrolled studies (Q2 only). Exclusion criteria were; a) research not published in English, b) qualitative studies, c) no comparative treatment (Q1), d) studies related to young offenders and e) dissertations.

Inclusion criteria for question three were; a) studies evaluating the feasibility of implementing the GLM, b) exploratory studies, c) case studies and d) offenders in hospital, prison or community settings. Exclusion criteria were a) research not published in English, b) studies related to young offenders and c) dissertations.

Search strategy: The following online databases were systematically searched - Cochrane Library, Medline, Embase, Web of Science, Psychinfo, Psycharticles, Opengrey, Social Services Abstracts and ASSIA. Databases were searched from their respective start date to 17th April 2015. The term 'Good Lives Model' was searched alone and in combination with the following: recidivism, forensic patients, mentally disordered offenders, offender rehabilitation, forensic psychiatry and forensic psychology. To improve sensitivity of the search strategy, a search of key authors was conducted, the GLM website publications list was searched (<http://www.goodlivesmodel.com/publications>15.02.15) and hand searches were completed of reference lists of selected studies and the review by Netto et al. (2014).

Risk of bias: The guidelines from the Non-Randomised Studies Methods Group of The Cochrane Collaboration (Reeves, Deeks, Higgins & Wells, 2011) were consulted when deciding on method of evaluating risk of bias. Although the Cochrane Risk of Bias tool for randomised trials (Higgins, Altman & Sterne, 2011) was not developed for non-randomised trials and all items may not be appropriate it can still be used with additional consideration given to the following: baseline characteristics of individuals as part of assessment of selection bias and heterogeneity between studies (Reeves et al., 2011).

Table 1: Cochrane Risk of Bias Tool

Selection Bias	
Random sequence generation.	Method used to generate allocation sequence described in enough detail to allow assessment of whether it should produce comparable groups.
Allocation concealment.	Method used to conceal the allocation sequence described in detail.
Baseline characteristics	Difference in baseline characteristics of individuals in different treatment groups and how this was controlled for through design e.g. matching.
Performance bias.	
Blinding of participants and personnel	Describe all measures used, if any, to blind study participants and personnel from knowledge of which intervention a participant received and if this was effective.
Detection bias	
Blinding of outcome assessment	Describe all measures used, if any, to blind outcome assessors from knowledge of which intervention a participant received and if this was effective.
Attrition bias	
Incomplete outcome data	Describe completeness of outcome data for each outcome, including attrition and exclusions from analysis. Were attrition and exclusions reported?
Reporting bias	
Selective reporting	State how the possibility of selective outcome reporting was examined and findings.
Other bias	
Other sources of bias.	State important concerns about bias not addressed in the other domains e.g. heterogeneity between studies.

The Structured Assessment of Feasibility Evaluation tool (SAFE; Bird et al., 2014) was used to review studies relevant to the implementation of the GLM. SAFE is an evidenced-based standardised tool developed to assess the feasibility of implementing a complex intervention within NHS mental health services and can also be used to review evidence for an intervention. It contains 16 questions which refer to facilitators and barriers to implementation (Table 2). It is recommended that items on the SAFE tool are not scored to categorise papers and instead items should be considered individually (Bird et al., 2014).

Table 2: SAFE Implementation Items

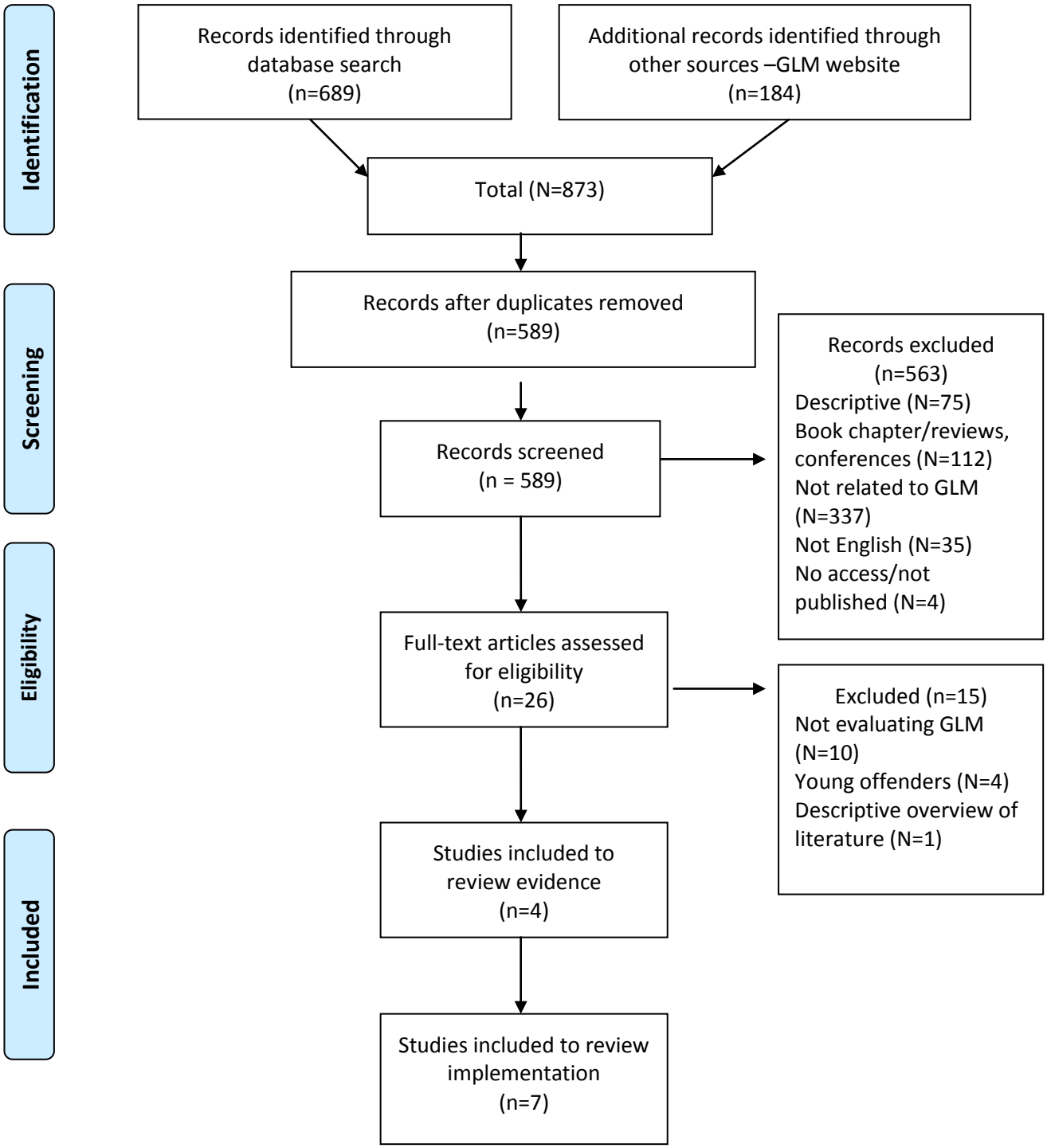
Barriers	**Facilitators**
Hours of staff training required	Applicable to population of interest
Complexity of intervention i.e. more than three separate components	Manualised intervention
Time needed to implement intervention	Flexibility of intervention i.e. can be tailored to context
Level of ongoing support and supervision required	Is the intervention effective i.e. is there an evidence base?
Human resources i.e. number of staff involved	Cost effectiveness of intervention
Material resources i.e. special equipment	Do goals match prioritised goals of NHS?
Cost of intervention	Ability to pilot the intervention
Serious or adverse events associated with intervention	Reversibility of the intervention

Results

Selection process

As shown in the PRISMA diagram, 589 abstracts were screened and 26 potentially relevant articles identified. These articles were independently reviewed by two researchers for eligibility using the criteria outlined above. Any disagreements were resolved through discussion. Two studies were identified to answer the first research question (Table 3) and two to answer the second (Table 4). Seven studies were identified to answer the third research question (Table 6). An independent researcher rated 45.5% (N=5) of included studies. The two researchers acknowledged bias in the same areas but initially there was disparity in the number of methodological flaws noticed. Following discussion, agreement was reached resulting in 100% inter-rater agreement (examples: appendix 1.2).

Figure 1: PRISMA Flow Diagram



The search strategy identified four treatment outcome studies (Barnett et al., 2014; Harkins Flak, Beech & Woodhams, 2012; Scoones, Willis & Grace, 2012 & Willis & Grace, 2008). No randomised controlled trials or non-randomised parallel group studies comparing GLM with any other control were identified. Studies comprised 1541 participants (1575 minus 34 participants sampled in two studies -Willis & Grace, 2008 and Scoones et al., 2012). All participants were male (100%). Mean age range was 36–44.8, although one study (Harkins et al., 2012) did not report data on age of participants. All participants lived in the community; 1300 in the UK (Barnett et al., 2014; Harkins et al., 2012) and 241 in New Zealand (Scoones et al., 2012; Willis & Grace, 2008).

Question 1: What is the evidence for the effectiveness of the GLM in reducing recidivism compared to any other control?

Two studies (Barnett et al., 2014; Harkins et al., 2012) utilised routinely collected data and evaluated the introduction of the GLM as a component of care. These services were overseen by the National Offender Management Service for England and Wales, an Agency of the Ministry of Justice. Both studies utilised similar outcome measures (Table 3), defined treatment change in similar terms (pro-offending attitudes, socio affective functioning and relapse skills) and contained similar treatment components. The studies were retrospective and used routinely collected data, collected by those implementing the intervention. No post intervention follow-up data were available and rates of recidivism were not reported in either study.

Harkins et al. (2012) compared an historical Relapse Prevention Group (n=701) to the introduction of the “Better Lives” Group, based on the GLM (n=76). Both groups comprised 12-sessions or 36 hours of intervention. The effectiveness of the intervention was evaluated in terms of change in pro-offending attitudes, socio-affective functioning and relapse skills. No differences were noted between groups in terms of attrition or outcome measures. Barnett et al. (2014) included two samples. Both compared an

historical Relapse Prevention Group (RPG) with the subsequent introduction of a Good Lives Group (GLG). Sample 1 (Community Sex Offender Group; CSOG) contained 255 participants (RPG; n=158; GLG; n=97). The RPG comprised 50 hours of intervention while the GLG was 37.5 hours. Sample 2 (The Thames Valley Sex Offender Group; TVSOG) contained 268 participants (RPG; n=163; GLG, n=105). Both groups comprised 22 sessions. Records of who started and completed treatment between April 2007 and April 2009 were entered into a national database by probation staff and annonymised data were accessed by researchers. No primary or secondary outcomes were specified. Overall there were many analyses of data producing a pattern of inconsistent and incoherent findings. On some measures the GLG was superior (e.g. improved scores on UCLA Loneliness Scale) whilst on other measures the RPG was superior (e.g. improved scores on Under-assertiveness Scale). Analyses were selective, based on subgroups and those who completed and thus were not based on an intention to treat principle. In an attempt to improve the robustness of outcomes, the authors constructed a "Treated Profile" for a selected subgroup of participants who had offended against children. This was defined as a normative comparison where a treated offender is "psychometrically indistinguishable from a sample of non-offenders" (p14). For those whom data were available and across the two samples the authors reported a larger proportion in the GLG had a "treated profile" post treatment compared to the RPG. Selecting such idiosyncratic treatment outcomes as a post-hoc evaluation is likely to be subject to substantial bias.

The limitations of both studies included the retrospective design, lack of randomisation and lack of explicit inclusion criteria. Further limitations were the methods of data collection which resulted in a significant proportion of missing data (Barnett et al., 2014, sampled 41% of offenders who completed the TVSOG or CSOG over a two year period) and disproportionate differences in the number of individuals who completed the two interventions (Harkins et al., 2012; RPG N= 701 and GLG N= 76). It is important to note that in both studies medium-high risk participants completed prior treatment modules and

so caution must be taken in attributing change solely to the effectiveness of the interventions evaluated. A significant limitation in Barnett et al. (2014) was difference in baseline characteristics between groups. Participants in the GLG had lower pre-treatment scores on the Beliefs about Children Scale and Under-assertiveness Scale. So while these participants sustained functional scores, individuals who had higher pre-treatment scores fared better in the RP treatment group.

Table 3: Evidence for the effectiveness of the GLM compared to relapse prevention

Authors	Participants	Setting	Treatment	Measures	Primary Outcome: Recidivism	Secondary Outcomes: Additional benefits of GLM
Harkins et al. (2012)	Male (100%) -sexual offenders -adult & child victims -low, medium & high risk N - 777: Relapse Prevention (RP) group: N=701; Better Lives (BL) group: N=76 Attrition rates: N= 269 (RP: 182 & BL: 87)	UK Northumbria Sex Offender Group Programme Community setting – on license, community order or probation	RP or BL module -12 sessions/36 hours RP: focus on avoidance goals BL: focus on approach goals	-UCLA loneliness scale -Interpersonal Reactivity Index -Social response inventory -Self esteem scale -Nowicki–Strickland Locus of Control -Victim empathy scale -Relapse prevention questionnaire -Beliefs About Children Scale	Recidivism rates not reported	Post treatment treated profile: 53% in RP & BL groups - no significant difference Attrition low – 1.5% of 269 – no significant difference between groups BL group – offenders and facilitators reported more positive perception of future compared to RP group
Barnett et al. (2014)	Male (100%) -sexual offenders -adult & child victims -low, medium & high risk Sample 1: Community Sex Offender Group (CSOG) N=255. Relapse Prevention Group (RPG) N=158, Mean Age: 41.7. Good Lives Group (GLG) N=97, Mean Age 44.8 Sample 2: Thames Valley Sex Offender Group (TVSOG) N=268 (RPG N=163, Mean Age 41.6, GLG N=10, Mean age 39.7 Attrition rates N=1486	UK Community programmes – on license, community order or probation	CSOG: RPG – 50 hrs GLG –37.5hrs TVSOG: RPG – 22 sessions GLG – 22 sessions	-Risk Matrix 2000 -UCLA - Interpersonal Reactivity Index -The Under-assertiveness Scale -The Nowicki-Strickland Locus of Control Scale - Victim empathy scale -Relapse prevention questionnaire -Beliefs About Children Scale	Recidivism rates not reported	TVSOG: GLG improved scores on UCLA. CSOG: RPG improved scores on Under-assertiveness Scale. No significant difference between groups on other measures. Greater proportion of GLG had “treated profile” post treatment compared to RPG Association between GLG and sustained functional scores Attrition low and no significant difference between groups

Question 2: Are there any additional benefits when the GLM is utilised as part of a wider rehabilitation programme?

Given the lack of studies identified which evaluated the effectiveness of the GLM, studies which evaluated the GLM as component of a wider rehabilitation programme were included. Two studies (Scoones et al., 2012; Willis & Grace, 2008) evaluated the GLM as a component of release planning. The primary aims of these studies were to evaluate the quality of community reintegration planning in relation to sexual recidivism. A secondary aim was to evaluate the GLM secondary goods as an aspect of reintegration planning. Both studies sampled child sex offenders released to the community following completion of a 32 week prison based treatment programme at the Kia Marama Specialist Treatment Unit, New Zealand. Detailed information on the content of the group programme was not provided and it is not clear if the intervention was informed by the GLM. Information on recidivism was obtained from the New Zealand Department of Corrections. The average follow up period was 7 years for recidivists and 6.5 years for non-recidivists in Willis and Grace (2008) and 11 years in Scoones et al. (2012). Both studies included recidivists for whom file data were available and a matched group of non-recidivists. No explicit exclusion criteria were mentioned.

Willis and Grace (2008) developed a coding protocol to measure the quality of reintegration planning for sexual offenders. They applied the tool retrospectively and reviewed files of 81 participants who completed the prison programme between 1990 and 2000. Files were rated blindly and adequate inter-rater reliability was reported. Items were scored to provide a total release planning score. They found that mean scores were higher for non-recidivists for accommodation, employment and GLM secondary goods, indicating potential benefits of utilising a good lives plan. Recidivists had significantly lower IQ scores, significantly higher scores on measures of sexual interests and pro-offending attitudes and greater overall deviance scores. The authors reported that when using general recidivism as an outcome variable, secondary goods remained significantly

greater for non-recidivists compared to recidivists, after controlling for IQ and overall deviancy. Researchers were unable to code participants good lives plan fully due to lack of available information. There was no follow up to evaluate achievement of goals specified in good lives plans. Scoones et al. (2012) employed the same coding protocol and retrospectively reviewed files for 194 participants (34 included in Willis & Grace, 2008) between 1993 and 2000. Files were rated blindly and almost perfect inter-rater reliability was reported. Recidivism rates were 13.3% for sexual recidivism, 12.8% for violent recidivism and 35.7% for other offending. The authors found that offenders' total release planning scores significantly correlated with sexual recidivism while controlling for overall deviance and static and dynamic risk factors. The study provided no information on participants' goals in relation to good lives primary goods. The study did not explore components of release planning individually and did not provide information in relation to the contribution of the good lives secondary goods in reducing recidivism.

Both studies attempted to match groups based on static risk scores in order to reduce selection bias. There was a lack of information in relation to baseline characteristics provided by Scoones et al. (2012). There were significant differences in baseline characteristics in Willis and Grace (2008). Therefore it is unclear whether matching groups on risk scores meaningfully reduced selection bias. The retrospective application of the coding protocol to participant information as a method of data collection, the lack of validation of the coding protocol used and lack of control group were limitations to both studies. Missing data led to exclusion of offenders who completed the programme in both studies (Scoones et al., 2012, N=22; Willis & Grace, 2008, N=17). A further limitation is the fact that prisoners voluntarily attended the Kia Marama Specialist Treatment Unit prior to the end of their prison sentence, which indicates motivation to engage, and is not necessarily representative of the wider offender population. Furthermore release planning was an integral aspect of the Kia Marama programme and as such may not be representative of offenders leaving other prison setting. Indeed Scoones et al. (2012)

stated there was little variation in scores and negative skew of total release planning scores indicated good planning for entire sample. Both studies controlled for IQ and deviance scores in analysis.

Table 4: GLM utilised as part of a wider rehabilitation programme

Authors	Participants	Setting	Treatment	Measures	Primary Outcome: Recidivism	Secondary Outcomes: Additional benefits of GLM
Willis and Grace (2008)	Male 100% (N=81) Sexual offenders - child victims Recidivists N= 39 Mean age: 36 Mean IQ 93 Mean time at risk - 7 years Non-recidivists N= 42 Mean age: 39 Mean IQ 101 Mean time at risk: 6.5 years	New Zealand Community	32 week prison based treatment programme aimed at reducing risk of recidivism and develop reintegration plans	-The Automated Sexual Recidivism Scale -Time at risk -Recidivism -IQ (4 subtests of WAIS) -Dynamic risk factors -Release planning - coding protocol to measure accommodation, social support, idiosyncratic risk factors, employment, motivation and GL secondary goods	GLM secondary goods significantly greater for non recidivists after controlling for IQ and overall deviance Correlation between secondary goods and general recidivism approached significance	None reported
Scoones et al. (2012)	Male 100% Sexual offenders - child victims N=194 (34 in Willis & Grace, 2008) Mean age: 41.7yrs (range19-74) Mean follow up: 11yrs	New Zealand Community	Same as above	-Release planning coding protocol as above -Recidivism -The Static 99 – static risk -The Allan et al, 2007, overall deviance score – dynamic risk: four variables – social inadequacy, sexual interests, anger/hostility, pro-offending attitudes	Recidivism rates: 13.3% sexual recidivism, 12.8% violent recidivism and 35.7% other Total release planning scores significantly correlated with sexual recidivism while controlling for overall deviance and static and dynamic risk factors	The study provides no information on participants' goals in relation to good lives primary goods.

Summary of findings: The results of the studies offered preliminary evidence for the effectiveness of the GLM. As outlined in Table 5 there is a risk of bias in all studies and as such, findings must be interpreted with caution (comprehensive description of risk of bias in appendix 1.3).

Table 5: Risk of Bias

Authors	Selection Bias – random concealment, allocation concealment, baseline characteristics	Performance Bias	Detection Bias	Attrition Bias	Reporting Bias
Harkins et al. (2012)	High Risk of bias	High Risk of bias	High Risk of bias	High Risk of bias	High Risk of bias
Barnett et al.(2014)	High risk of bias	High Risk of bias	High Risk of bias	High Risk of bias	High Risk of bias
Willis and Grace (2008)	Unclear risk of bias	High Risk of bias	Low risk of bias	Unclear risk of bias	Low risk of bias
Scoones et al. (2012)	Unclear risk of bias	High Risk of bias	Low risk of bias	Unclear risk of bias	High Risk of bias

Question 3: What are the necessary factors for implementing the GLM?

As outlined in Table 6, six of the papers reviewed for this research question were case studies. They comprised 13 participants (Male, N=12) and were conducted in secure psychiatric facilities (N=2), prison (N=2) and the community (N=3). One study (Barnao et al., 2010) sampled participants across two settings. The remaining study reviewed for this question (Willis et al., 2014) evaluated 13 group treatment programmes in prison (N=6) and community (N=7) settings. The SAFE tool (Bird et al., 2014) was used to guide discussion in consideration of the factors necessary for successful implementation of the GLM.

Intervention Characteristics: One of the papers (Barnao et al., 2010) reconstructed case studies to demonstrate how the GLM can be applied to a forensic population and treatment was not informed by the GLM. In the remaining studies interventions were informed by the GLM and there was similarity in treatment components described across studies. Three studies (Lindsay, Ward, Morgan, & Wilson, 2007; Ward & Fortune, 2013; Whitehead et al., 2007) stated that treatment contained five components, one study (Gannon et al., 2011) outlined nine modules and one (Willis et al., 2014) outlined eleven components. The factors mentioned across all studies included socialisation to the model, development of an individualised good lives plan, identification of personally salient primary goods (and rating of attainment), identification of secondary goods needed to achieve primary goods, and development of approach focused goals. Three studies (Gannon et al., 2011; Lindsay et al., 2007; Whitehead et al., 2007) stated that treatment was based on a combination of the GLM and RNR models. Three studies (Willis et al., 2014; Ward, 2002; Ward & Fortune, 2013) stated that the GLM should be used to enhance not replace the RNR model. Interventions tended not to be manualised but it appears that these core components should be included in order to adhere to the principles of the GLM. Willis et al. (2014) state that their evaluation identified strength-based treatment manuals were used to inform interventions in 8 of the 13 group programmes reviewed. They were largely relapse prevention programmes and only 3 had a specific GLM component in the treatment guide. Potential facilitators of the GLM were its flexibility to be tailored for different environments (prison, community, forensic mental health units) and its applicability to the population of interest (sexual offenders).

Resource Consequences: A significant limitation was the lack of information relating to resources necessary for implementation. All but one study (Gannon et al., 2011) failed to provide details on what professionals delivered the intervention. No study provided details of training or supervision requirements making evaluation of human resources associated with the intervention impossible. No study provided details of the material resources

necessary. Furthermore no study provided details of the procedures and costs associated with setting up the intervention. Only one study provided information in relation to time taken to complete the intervention. Gannon et al. (2011) stated that the intervention lasted for 7.5 months with weekly 2 hour group sessions and 60–90 minute individual sessions (total duration 90-105 hours). Lindsay et al. (2007) indicated that the development of a comprehensive life map can take between six to eight sessions but did not indicate length of overall treatment.

Effectiveness: There is limited evidence for the effectiveness of the GLM in reducing recidivism. The present studies offered descriptive accounts of the benefits for individual case studies but there was a lack of psychometric data to evidence effectiveness. A positive factor was that all studies acknowledged the dual focus of the intervention - promoting wellbeing and reducing risk. Limitations were variation in outcome measures used and lack of measures specifically related to the GLM or recovery. There were no adverse consequences reported.

Summary: It was difficult to accurately evaluate potential barriers compared to facilitators of implementation due to lack of information in relation to resources and costs associated with the development and delivery of the intervention. There was a lack of information in relation to hours of staff training required, time needed to implement the intervention, level of support and supervision required, number of staff needed to deliver the intervention and material resources necessary. One potential barrier identified was the complexity of the intervention i.e. more than three separate components (Bird et al., 2014). Although treatment manuals have been published these were not routinely referred to in studies. In terms of the potential facilitators there was evidence that the GLM is applicable to the population of interest. The literature also demonstrated the flexibility of the GLM for use in prison, community and forensic mental health settings, although, Gannon et al. (2011) highlighted that the degree of heterogeneity amongst mentally disordered offenders can

make group based interventions problematic. The GLM is in keeping with the current ethos of mental health services i.e. to promote recovery. It is also in keeping with the dual responsibility of forensic mental health services to promote mental health and reduce risk of reoffending. No direct adverse consequences were highlighted in the literature although inappropriate implementation i.e. neglecting RNR principles and criminogenic needs could potentially lead to increase in recidivism (Barnett et al., 2014; Willis et al., 2014). The philosophy of the GLM in promoting well being and the strong focus on collaboration, respect and honesty indicates it is unlikely to be adversarial for participants and it would be possible to terminate the intervention should it result in any negative consequences.

Table 6: Implementation of the GLM

Author and Date	Participant Characteristics - population, gender, age, type of study	Intervention components	Resources - training, supervision, meetings, delivery, time frame, materials	Evaluation of Intervention – intended outcomes, measures, findings	Limitations
Barnao et al. (2010)	Mentally disordered offenders (MDO) (N=3; 2 male, 1 female) Mean age 40 (range 28 – 59) Offence type: murder: 2, stalking: 1 Setting: secure (N=2) & community (N=1) New Zealand Case studies	-Medical management of psychotic symptoms, -Social & emotional skills development -Psycho-education re: mental health & offending, CBT Increase meaningful activity NB: Treatment not informed by GLM - case studies reconstructed to use GLM to conceptualise offending in the context of mental illness	No information in relation to resources necessary for the use of GLM with a forensic population	Not applicable	Treatment plan not informed by the GLM instead it shows how it can be modified for use in a forensic mental health setting
Gannon et al. (2011)	MDO (N=5: male) Mean age 42 (range 29-60) Low risk N=2; moderate risk N=2; high risk N=1 Offence Type: Sexual N=4, Violent N=1 Setting: secure, UK Mean length of stay 2.4yrs (range 1 - 3.8) Case studies	Treatment Group based on GLM and RNR Models, CBT, skills-based & psychotherapeutic elements 9 modules: -Group formation & motivation -Understanding GLM & link to risk, rate primary goods -Understanding offending, sexual arousal & fantasy -Coping skills -Offence supportive thinking -Victim awareness & empathy -Intimacy & relationships -Recognising risk & leading a good life	Weekly 2hr group session facilitated by two psychologists & another health care worker & weekly 1-1.5hr individual session with psychologist 7.5 months duration (90-105 hrs) No information regarding training, supervision, material costs	**Intended outcome** – show how GLM used with MDO **Measures:** Paulhus Deception Scale, Self Esteem Questionnaire, The Sex Fantasy Questionnaire, Rape Scale, Children & Sex scale, Victim Empathy Scale, Emotional Loneliness Scale, Relapse Prevention Questionnaire, Locus of Control Scale, GLM Rating **Findings:** Quantitative analysis of data not conducted, descriptive account provided via case studies indicated progress	No control group Lack of analysis on data

Author and Date	Participant Characteristics - population, gender, age, type of study	Intervention components	Resources - training, supervision, meetings, delivery, time frame, materials	Evaluation of Intervention – intended outcomes, measures, findings	Limitations
Lindsay et al. (2007)	N=2 Male Age: 29 & 42 Offence type: sexual Setting: community Case studies	-Timeline integrating the Self-Regulation Model (SRM) of Offence and Relapse Process & GLM -Identify positive & negative self resources -Develop projected (pro-social & anti-social) pathways -Other treatments completed - anger management, alcohol treatment, sex offender treatment (offence disclosure, pathways to offending, cognitive distortions, victim empathy & reduction of risk factors) -Acquisition of internal & external conditions necessary to achieve personally valued & socially acceptable approach goals	No information provided In discussion authors indicated creating an individual's life map with pro-social & anti-social projections can take 6-8 sessions	**Intended Outcomes:** To operationalise and clinically evaluate (via case studies) a combination of the GLM and SRM **Measures:** Not reported **Findings:** Neither individual committed an offence in 5 years	Lack of information in relation to who delivered the treatment, time spent with client per week, total number of sessions, supervision arrangements or outcome measures used.
Ward (2002)	N=1 Male Age 40 Offence type: Sexual Setting: prison Case study	-Develop formulation -Identify superordinate primary good & other important primary goods -Identify secondary goods -Explicit construction of a good lives plan e.g. detailed treatment plan to help individual acquire internal & external factors necessary to achieve primary goods	No information provided	No information provided	Lack of information in relation to resources and outcomes

Author and Date	Participant Characteristics - population, gender, age, type of study	Intervention components	Resources - training, supervision, meetings, delivery, time frame, materials	Evaluation of Intervention – intended outcomes, measures, findings	Limitations
Ward and Fortune (2013)	N=1 Male Age: 32 Offence type: sexual Moderate – high risk Prison setting New Zealand Case study	1) Identifying social, psychological & material aspects of offending, risk, criminogenic needs. Identify social, physical & psychological resources at time of offending 2) explore primary goods & association with offending 3) Identify primary goods & develop good lives plan (driven by values, goals & identity) 4) Identify secondary goods & elaborate upon good life plan 5) Integrate information regarding internal & external needed to achieve primary goods into plan	No information in relation to who delivered the treatment, time spent with client per week, total number of sessions, supervision arrangements	**Intended outcomes:** Enhance psychological wellbeing and reduce risk of recidivism **Outcome Measure:** not reported **Findings:** no evaluation of treatment reported	Lack of information in relation to resources and outcomes
Whitehead et al. (2007)	N=1 Male Age: 28 Offence type: violent & sexual High risk Community setting following release from prison Case study	1) identify treatment goals, primary goods & means to achieve, increase treatment readiness, establish new personal identity 2) conceptulise new direction, develop approach goals in line with primary goods, criminogenic needs & risk management 3) Develop good lives case formulation (including previous ways of securing goods, lack of primary goods, conflict among goals, potential barriers) 4) Develop a good lives plan based on formulation, specific goal setting 5) goal attainment, monitor progress	Unclear who delivered the treatment No information in relation to time spent with client per week, total number of sessions, supervision arrangements	**Intended Outcomes** Goods promotion & risk management **Measures:** Risk of Conviction by Risk of Imprisonment (actuarial risk assessment tool used by New Zealand Department of Corrections), Psychopathy Checklist: Screening Version, **Findings:** Violence reduction, increased treatment compliance & life changes e.g. pro-social activities & relationships, reduced substance use	Lack of information in relation to resources. No analysis of change in terms of risk rating.

Author and Date	**Participant Characteristics - population, gender, age, type of study**	**Intervention components**	**Resources - training, supervision, meetings, delivery, time frame, materials**	**Evaluation of Intervention – intended outcomes, measures, findings**	**Limitations**
Willis et al. (2014)	Multi site study – 13 group sex offender treatment programmes Adult males Setting: prison (n=6), community (N-5), civil commitment centre (N=2) USA (N=10) & Canada (N=3)	1) Programme aims & orientation – focus on risk reduction & wellbeing enhancement 2) Assessment of risk, goals, primary goods & means to achieve 3) Individualised intervention plan – good lives plans 4) Content i.e. components of risk reduction & goods promotion, approach goals, target range of primary goods, discharge planning 5) Delivery –i.e. respectful, non confrontational, collaborative. Intensity, content & process individually tailored	Lack of information in relation to training, supervision requirements, length of delivery	**Intended outcome:** evaluate implementation of GLM group interventions **Measures:** Coding protocol used to evaluate programme consistency to GLM **Findings:** weak (N=2), moderate (N=7), good (N=4) **Factors supporting GLM implementation** -Client and staff responsiveness, access to literature, professional links, therapeutic ethos, support of programme administrators, external support **Factors hindering GLM implementation** - policy & law, lack of resources, punitive social attitudes, community barriers, lack of support from programme administrators, lack of knowledge & understanding of GLM	Lack of information in relation to resources

Discussion

The aims of this paper were a) to review the evidence for the effectiveness of the GLM in reducing recidivism compared to other approaches, b) to explore any additional benefits when utilised as part of a wider rehabilitation programme and c) to consider the factors necessary to implement the model. The systematic search of the literature identified no randomised or non-randomised parallel control trials. It identified four retrospective studies; two which used routinely collected data comparing group interventions before and after the introduction of the GLM as a component of care and two which evaluated release planning for offenders who completed a prison based treatment using a coding protocol which included good lives secondary goods.

Two studies did not find significant differences between the GLM and a historical control and they did not report recidivism rates (Barnett et al., 2014; Harkins et al., 2012). One of the studies (Willis & Grace, 2008) which coded release planning found that secondary goods were greater for non-recidivists compared to recidivists after controlling for naturally occurring differences amongst the groups. All studies had significant risk of bias and therefore it is uncertain whether the GLM leads to an improvement or deterioration in outcomes for offenders. The review identified a significant lack of evidence to support claims that the GLM is an empirically validated intervention that is effective in reducing recidivism.

The SAFE tool (Bird et al., 2014) was used to review research relating to the process of implementing the GLM. The review identified significant gaps in the literature in relation to resource consequences associated with implementation making comprehensive evaluation difficult. In terms of facilitators identified by the SAFE, there was evidence that the GLM could be piloted and tailored for use in a variety of settings and is in keeping with the recovery orientation of the health service. Recovery is a process of developing a meaningful life despite mental illness and involves relationships, connection to community,

hope and optimism, identity and empowerment (Leamy et al., 2011). Recovery oriented mental health services focus on individual strengths rather than illness and acknowledge individual values and perspectives (Wallcraft et al., 2007).

There were a number of potential barriers identified by the SAFE which have clinical governance implications. Although the literature suggests a tentative link between a good lives approach and recidivism, there is a lack of evidence to support the effectiveness of the model. Studies which report links between GLM and recidivism do not appear to directly evaluate the model. For example, Bouman, Schene & de Ruiter (2008) reported a link between subjective well being and official recidivism data over a follow-up period of three years but this was not an evaluation of a good lives intervention. Farmer, Beech and Ward (2012) reported that sexual offenders who desisted from further offending reported greater optimism for their future, greater sense of personal agency and greater sense of belonging compared to those who did not desist but again this was not an evaluation of a good lives intervention. In order for interventions to be implemented within the health service it is essential that there is a sound evidence base (Department of Health, 2011; NHS Education for Scotland & the Scottish Government, 2011). The lack of research to support the efficacy of the GLM is likely to be a significant barrier to implementation.

A further barrier is the lack of transparency in relation to the resource implications which makes it difficult for reviewers to evaluate the facilitators and barriers, for clinicians to plan interventions and for managers to lend support to its implementation. Although there are books published regarding implementation of the GLM e.g. Yates, Prescott, and Ward (2010), these are not referred to in the empirical literature. The lack of evidence-based manuals impacts upon appropriate identification of training and supervision needs and clarity regarding skills and competencies necessary to implement interventions. The empirical literature did identify treatment components linked to theoretical concepts that should be included to ensure integrity to the model and outlined the necessity of

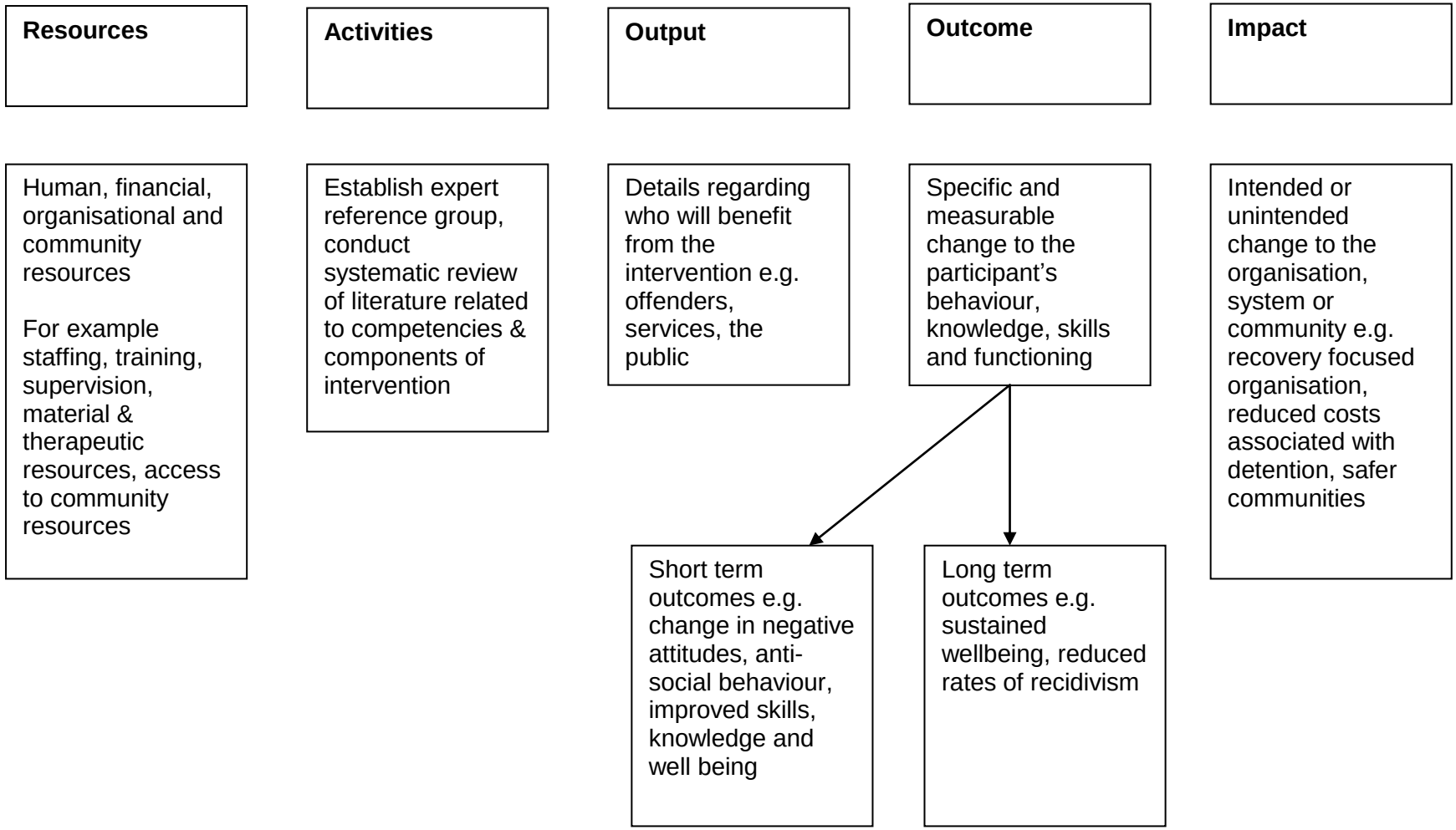
incorporating the principles of the RNR model. The lack of evidence for effectiveness of treatment manuals also makes it difficult to accurately evaluate the quality of interventions and measure its effectiveness. This could be a contributory factor in relation to the lack of robust research detailing the efficacy of the model. It would appear that there is no widely used validated good lives outcome measure. The reliability and validity of a newly developed self-report measure of recovery based on the GLM has been demonstrated, although further validation is necessary (Quill, 2015).

Research Implications

The methodological flaws in the literature highlight the need for more robust research in the field. This is not unique to the GLM. There are difficulties establishing robust evidence in other areas of forensic mental health practice due to a lack of randomised controlled trials (RCTs) and systematic reviews in comparison to general mental health (Taylor, Walker, Hillier, Murphy, & Gunn, 2015). RCTs comparing the GLM to an alternative treatment approach, to evaluate the effectiveness of the GLM in terms of well being and recidivism in the short and longer term, would greatly contribute to the evidence base. A key barrier to conducting a RCT of GLM is that it is a systems based approach which involves changing multiple aspects of a treatment milieu. Future research on the GLM should attempt to improve upon the methodological quality of research to date, for example, prospective observational studies rather than retrospective analysis, systematic data collection and use of a control group (even if not randomised). Attempts could be made to conduct RCTs through blinding researchers collecting and analysing data. Cluster RCTs may also offer a solution in relation to developing appropriate robust evaluations of GLM. The majority of literature relates to sexual offenders and it would be of interest to carry out pilot studies to evaluate the effectiveness of the model with non-sexual offenders if the model is to be used within forensic mental health services where the population is heterogeneous.

In addition to the need for further research to evidence the efficacy of the GLM, there is also a need to investigate the process of implementation. This could be informed by the UK Medical Research Council (MRC) framework for complex interventions (Moore et al., 2015). This would allow involvement of multiple stakeholders including staff, service users and carers and incorporate multiple methods including qualitative studies, feasibility, pilot and full-scale studies and eventually larger scale RCTs. The GLM meets the MRC definition of a complex intervention i.e. an intervention that targets difficult behaviour and comprises multiple components which interact to produce change in relation to a range of outcomes (Moore et al., 2015). Process evaluations of complex interventions involves reviewing the resources necessary for implementation, the quantity and quality of what is delivered, the factors leading to change and the context in which interventions are delivered (Moore et al., 2015). A logic model can be used to present this information diagrammatically and is a helpful evaluation tool that facilitates effective program planning, implementation, evaluation and identification of areas in need of further development (Kellogg Foundation, 1998). Figure 2 demonstrates the use of a logic model to evaluate the GLM. This is a simplistic example, presented to demonstrate how to begin a process evaluation of the GLM. In reality such a plan would need to be developed collaboratively with stakeholders. The competency framework for working with individuals with psychosis and bipolar disorder, developed by Roth and Pilling (2013), could be referred to when considering the development of an implementation programme for the GLM. Roth and Pilling (2013), in consultation with an expert reference group, reviewed relevant research, policy documents and intervention manuals and based on their findings outlined training requirements, supervision needs, necessary clinical competencies and specific treatment components. They also detailed how this framework of competencies and guidance on best practice can be of benefit to those commissioning and developing services. Furthermore, they highlight the utility of the framework in relation to clinical governance by providing a means of assessing the quality of interventions delivered.

Figure 2: Example of Logic Model to evaluate the implementation of the GLM



Clinical Implications

The GLM is in keeping with current priorities for mental health services, including, forensic services i.e. that services are recovery focused and utilise strength-based treatments. Furthermore, there is some evidence that the principles of the GLM are acceptable and relevant to offenders. One study found that 98% of 338 male sexual offenders reported that learning how to meet their needs in more adaptive ways and creating more satisfying lives were helpful components of treatment (Levenson, Macgowan, Morin, & Cotter, 2008). One of the studies reviewed (Harkins et al., 2012) conducted qualitative analysis with a subgroup of participants and reported that those who received treatment based on the GLM perceived it as positive and future focused.

Limitations of the review

The Cochrane Risk of Bias tool was not developed to review non-randomised controlled trials which could potentially lead to a risk of over emphasising risk of bias in the papers reviewed. Tools to assess non-randomised trials are not as robust as those for randomised trials and non-randomised trials tend to be of poor methodological quality and poorly reported. Both of these factors make consistent assessment of methodological quality and risk of bias across studies problematic (Reeves et al., 2011).

It was outside the scope of this review to include book chapters describing treatment manuals for GLM implementation. Future work could focus on systematic assessment of published treatment manuals for developing consensus on training needs and competencies necessary for implementation.

Conclusion

The systematic search conducted identified a lack of evidence to support the efficacy of the GLM as an empirically validated intervention that is effective in reducing recidivism. This is in contrast to the way in which it is presented by its developers as an evidence-

based model of offender rehabilitation, which has led to its endorsement within prison, community and mental health settings. The review also identified significant gaps in the literature in relation to factors necessary for the implementation of interventions based on the model. The principles of the model are based on fundamental concepts of human needs and fit well with the literature on mental health recovery. The review highlighted the need for a comprehensive framework to outline specific treatment components, skills and competencies necessary to deliver interventions and means of assessing quality and effectiveness of interventions. It also highlighted the necessity of further research on the efficacy of the model if interventions based on its principles are to be used to treat offenders with complex criminogenic and mental health needs.

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Chapter 2: Major Research Project

Developing a Scale for Assessing the Forensic Experience of Recovery: the SAFER questionnaire

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Plain English Summary

Background: Recovery from mental illness is a personal experience. It is a journey where people learn to live in a way that is in keeping with their personal values despite mental illness. The CHIME model of recovery highlights five main processes. These are connections to family, friends and community, hope and optimism, sense of identity, meaning and purpose in life and empowerment. People in forensic mental health services go through a similar process of recovery. The Good Lives Model is an approach to offender rehabilitation that fits with the philosophy of recovery. The model suggests that everyone wants purpose to their lives and that offenders have the same basic human needs as everyone else. Psychological interventions based on the model helps offenders develop the skills they need to achieve their needs without offending. There are no well researched self-report measures of recovery in forensic mental health, based on models of recovery and offender rehabilitation. **Aims:** To develop a self-report recovery measure for forensic service-users based on the Good Lives Model and the CHIME model and to analyse the reliability and validity of the measure. **Methods:** The CHIME model of recovery and Good Lives Model of offender rehabilitation were reviewed to identify connections between the models. A self-report recovery measure was developed based on these connections. The measure was called SAFER: Scale for Assessing the Forensic Experience of Recovery. A study to evaluate the reliability and validity of the SAFER was designed. Following ethical approval and informed consent, 46 participants from low, medium and high secure hospitals completed the SAFER and other validated measures of recovery. Each participant's doctor was also asked to complete a recovery measure. **Findings and conclusions:** The results found the SAFER was a reliable and valid measure of recovery. Participants thought that it was interesting, positive and client focused and that the items were personally relevant to their recovery. The results found that participants' and doctors' view of recovery were different. More research is needed to further evaluate the reliability and validity of the SAFER with a larger group of forensic mental health service users.

Developing a Scale for Assessing the Forensic Experience of Recovery: the SAFER questionnaire and Clinical Research Portfolio

Abstract

Background: A conceptual framework of recovery was developed through systematic identification of five key processes - Connectedness, hope/optimism, identity, meaning in life and empowerment (CHIME). There are increasing efforts to implement recovery focused interventions in forensic setting. To date there has not been a self-report recovery measure developed for this population. **Aims:** The primary aim was to develop a self-report recovery measure for forensic service-users, conceptually based on the Good Lives Model (GLM) of offender rehabilitation and the CHIME model of recovery. Secondary aims were to explore the concurrent validity, test-retest reliability and internal consistency of the measure. **Method:** The processes of recovery outlined in CHIME and the description of primary goods from the GLM were explored to identify overlapping constructs. When researchers reached a consensus on the connection between constructs, items for the questionnaire were developed. The questionnaire was titled SAFER (The Scale for Assessing the Forensic Experience of Recovery). A cross-sectional pilot study was devised to evaluate concurrent validity, test-retest reliability and internal consistency of the SAFER. **Results:** Forty-six forensic inpatients in low, medium and high secure facilities participated. Results show the SAFER had concurrent validity, good test-retest reliability and internal consistency. **Conclusions:** The findings offer preliminary evidence for the validity and reliability of the SAFER. Further, larger scale research is necessary to evaluate additional psychometric properties. **Declaration of interest:** none.

Keywords: Recovery, Forensic, Outcome Measures

Introduction

Recovery is not simply about symptom reduction. It is a subjective and individualistic process that involves learning to adjust ones attitudes, values, skills and goals in order to live a meaningful life despite mental illness (Anthony, 1993). It also involves learning to manage stigma, discrimination and reduced opportunities experienced as a result of mental illness (Anthony, 1993). Recovery involves developing a greater understanding of mental illness, taking control through responsibility and choice and developing hope (Wallcraft, Tew, Griffiths & Nicholls, 2007). A recent review found potential barriers to recovery included negative interactions and social isolation, lack of confidence, uncertainty about relapse and hopelessness, while facilitators included adjustment and coping, social support, close relationships and belonging (Soundy et al., 2015). Within secure settings positive relationships, perception of staff support and general ward environment have been found to positively impact upon attachment to the service and recovery (Campbell, Allan & Sims, 2014). The CHIME model of recovery offers a conceptual framework for understanding recovery through systematic identification of five key process - Connectedness, hope and optimism, identity, meaning in life and empowerment (Leamy, Bird, Le Boutillier, Williams & Slade, 2011).

Within many countries including the United Kingdom (UK), United States of America (USA) and Australia there has been a shift from the medical model of mental illness and an increased focus on recovery within mental health services (Shepherd, Doyle, Sanders & Shaw, 2015). A recovery approach should focus on individual strengths rather than illness and should acknowledge values, perspectives and cultural diversity (Wallcraft et al., 2007). Despite the widely promoted ethos of recovery oriented mental health services, there is a lack of clarity regarding best practice (Slade, Williams, Bird, Leamy & Boutillier, 2012). The CHIME model can potentially offer an empirically based theoretical underpinning for recovery oriented research to inform clinical interventions and influence service policies (Slade et al., 2012). The principles of recovery are equally applicable in

forensic mental health services and research has highlighted that forensic service users identified similar processes as relevant for their recovery. For example, people detained in a high security hospital identified that the development of trust, positive relationships and valued outcomes were important tasks of recovery (Laithwaite & Gumley, 2007). Turton et al. (2011) carried out qualitative research within specialist mental health services, one of which was forensic and found that hope, engagement, autonomy, insight, symptom management, choice and control and sense of self-worth were important recovery tasks.

Adopting a recovery approach within forensic settings can bring challenges. Forensic service users are detained under mental health and/or criminal legislation and obliged to engage in treatment. There is a balance between respecting the rights of service users and protecting public safety. As a result forensic service users can be detained for longer than those in general psychiatric settings and long after psychotic symptoms have subsided (Shinkfield & Ogloff, 2014). A recent review of qualitative studies of forensic service users experiences of recovery identified the paradox of security i.e. participants identified physical and relationship safety as important for recovery yet feeling restricted, lack of personal space and lack of clarity around length of stay was counterproductive to the recovery process (Shepherd et al., 2015). It can be difficult to manage autonomy, independence and promote choice within a forensic setting (Turton et al., 2011). Furthermore, forensic service users have additional tasks to manage e.g. learning to understand their offending behaviour and managing restrictions (Simpson & Penney, 2011). They are also likely to face stigma and discrimination due to their offences (Turton et al., 2011), and this stigma can be a potential barrier to accessing support (Shepherd et al., 2015).

Despite these challenges recovery is possible and one model of offender rehabilitation, consistent with the philosophy of recovery, is the Good Lives Model (GLM). This is a strength-based approach which promotes psychological wellbeing and aims to reduce

recidivism. The GLM draws on psychological, social, biological and anthropological research and is based on the premise that offenders have the same basic human needs as everyone else (Willis & Ward, 2013). The model suggests that everyone aims to construct a sense of purpose in their lives, which is achieved through the pursuit of primary goods i.e. knowledge, excellence in play and work, autonomy, inner peace, relatedness, spirituality, happiness and creativity (Ward & Brown, 2004). Offending behaviour occurs when someone lacks the capacity to achieve or has inappropriate means of securing primary goods (Whitehead, Ward & Collie, 2007). The GLM takes into account individuals' preferences and values and treatment is based on personally salient goals and designed to support individuals to develop skills necessary to meet their needs in a more socially desirable manner (Ward & Brown, 2004).

Due to the multi-faceted definitions within the literature and the subjective nature of recovery it can be difficult to accurately measure (Simpson & Penney, 2011) but a number of self–report questionnaires have been validated for use in general mental health settings. The Individual Recovery Outcomes Counter (I.ROC) is based on mental health charity Penumbra's HOPE (home, opportunity, people and empowerment) model of recovery and was developed with service users in Scotland. Its reliability and validity has been demonstrated (Monger, Hardie, Ion, Cumming & Henderson, 2013). The Recovery Assessment Scale (RAS) was developed collaboratively with service users in the US. It correlates with quality of life, self esteem and empowerment (Corrigan, Giffort, Rashid, Leary & Okeke, 1999) and contains five factors reflective of recovery - personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and not being dominated by symptoms (Corrigan, Salzer, Ralph, Sangster & Keck, 2004). The Questionnaire of the Process of Recovery (QPR) is a self-report measure with interpersonal and intrapersonal components which was developed through analysis of interviews with service users in England (Neil et al., 2009).

Within forensic mental health, there tends to be a greater focus on the development of validated risk assessment tools rather than tools which assess wellbeing and recovery (Shinkfield & Ogloff., 2014; Thomas et al., 2008). A systematic review of routine outcome measures for forensic mental health services found the majority were clinician rated (Shinkfield & Ogloff, 2014). One example is the Dundrum-4 clinician rated recovery measure. It was developed and validated in a high secure forensic hospital in Ireland and is one component of a five part structured professional judgement instrument for assessing the need for therapeutic security (Davoren et al., 2013). The review did identify two client report measures of recovery: The Illness Management and Recovery Scale (IMR) and the Mental Health Recovery Measure (MHRM). Neither was developed specifically for forensic mental health. The MHRM has been validated in forensic services (Bullock, Wuttke, Klein, Bechtoldt, & Martin, 2002) but does not include items to assess risk. There are concerns regarding the applicability of general mental health outcome measures, not designed for forensic populations, being used in forensic services due to the complex and co-morbid mental health difficulties and criminogenic needs of forensic service users (Shinkfield & Ogloff, 2014). This identifies the need for a self-report recovery measure specifically designed for forensic service users based on models of offender rehabilitation and recovery. From review of the literature (Quill, 2015) there does not appear to be a widely used validated GLM measurement tool. Such a tool could evaluate the effectiveness of the model and measure recovery.

Aims: The primary aim of this research was to develop a self-report measure of recovery for forensic service users, conceptually based on the GLM and CHIME. The secondary aims were to explore the concurrent validity, test-retest reliability and internal consistency of the questionnaire developed – the SAFER.

Hypotheses:

1) A moderate positive correlation (r>0.4) between the SAFER and the I.ROC, the RAS and the QPR was predicted.
2) A moderate correlation (r>0.4) between participants' perception of recovery, as measured by the SAFER, and clinicians' perception of recovery, as measured by the Dundrum-4, was predicted.
3) It was hypothesised that the SAFER would have good test-retest reliability as demonstrated by a correlation (r>0.7) between participants' responses at two time points, two weeks apart.
4) It was predicted that the SAFER would have good internal consistency as indicated by Cronbach Alpha (α>0.8).
5) It was predicted that there would be a moderate correlation (r>0.4) between higher scores on anxious and avoidant attachment scales, as measured by the Psychosis Attachment Measure (PAM), and lower scores on the SAFER.

Methods

Design: This was the first phase of a psychometric study designed to evaluate concurrent validity, test-retest reliability and internal consistency of a newly developed self-report measure of recovery – the SAFER.

In line with this, a cross-sectional study was devised. Sample size was calculated *a priori* based on estimation of concurrent validity of the SAFER. The statistical software G-Power was used (Faul, Erdfelder, Buchner, & Lang, 2009). A two sided test was calculated with alpha set at 5%. A null hypothesis of 0 (no correlation) and an alternative hypothesis of correlation 0.4 at 80% power was assumed. A sample size of 46 was needed to detect a correlation of 0.4 (table 7).

Table 7 – Sample Size Calculation

Power	Correlation								
	0.2	0.25	0.3	0.35	0.4	0.45	0.5	0.55	0.6
80%	193	123	84	61	46	36	29	23	19

Participants: Inclusion criteria were a) male and female forensic mental health inpatients, b) low, medium and high secure hospitals, c) English speaking, d) no minimum length of stay required. Exclusion criteria were a) patients who do not have capacity to consent based on the advice of responsible medical officers (RMO).

Measures: Concurrent validity was evaluated using the I.ROC, the RAS, the QPR and the Dundrum-4. The PAM was used to explore correlations between attachment style and recovery.

Individual Recovery Outcome Counter (I.ROC; appendix 2.2): This is a 12 item self-report measure rated on a 6 point scale. It has high internal consistency (α=0.86), concurrent validity with the RAS and the Behaviour and Symptom Identification Scale and factor analysis revealed no redundant factors (Monger et al., 2013). Good internal consistency was also found in the current study (α=0.85).

Recovery Assessment Scale (RAS; appendix 2.3): This is a 41-item self-report measure rated on a 5 point scale. It has good test-retest reliability (*r* = 0.88) and internal consistency (Cronbach's alpha = 0.93) and positively correlates with the Self-Esteem Scale, Empowerment Scale, Quality of Life Interview and Social Support Questionnaire (Corrigan et al., 1999). There was good internal consistency in the current study (α=0.90).

Questionnaire on the Process of Recovery (QPR; appendix 2.4): This is a 22 item self-report questionnaire rated on a 5 point scale. It has good internal consistency (Cronbach's alpha; subscale 1 α=0.94; subscale 2 α=0.77), test-retest reliability (intrapersonal subscale *r*=0.874, *p*=0.001 and interpersonal subscale *r*=0.769, *p*=0.001) and concurrent validity with the General Health Questionnaire, the Making Decisions and Empowerment Scale and the Schizophrenia Quality of Life Scale (Neil et al., 2009). There was good internal consistency in the current study (intrapersonal subscale α=0.83 and interpersonal subscale α=0.74).

Dundrum-4 (appendix 2.5): This is a clinician rated measure containing six items, rated on a 5 point scale. It has significant inter-rate reliability, internal consistency (Cronbach's alpha 0.887) and significantly correlates with the Positive and Negative Symptom Scale (r = 0.596), the Global Assessment of Function (-0.673) and the HCR-20 dynamic items (r = 0.70) (O'Dwyer et al., 2011). There was good internal consistency in this study (α=0 .73)

Psychosis Attachment Measure (PAM; appendix 2.6): This is a 16 item self-report questionnaire which uses a four point Likert scale to assess anxious and avoidant attachment styles. A range of studies have demonstrated internal consistency - Cronbach's alpha coefficients ranging from 0.70 to 0.86 for the anxiety dimension and from 0.60 to 0.91 for the avoidance dimension (Gumley, Taylor, Schwannauer, & MacBeth, 2014). Internal consistency was demonstrated in the current study for the anxious subscale (α=0.77) but not the avoidance subscale (α=0.62).

Development of SAFER: The questionnaire was developed under supervision of Professor Andrew Gumley, University of Glasgow, and Dr Emma Drysdale and Dr Heather Laithwaite, Consultant Clinical Forensic Psychologists. To create a conceptual framework, the five processes of recovery outlined in CHIME (connectedness, hope and optimism about the future, identity, meaning in life, empowerment) and the description of

primary goods from the GLM (life, knowledge, excellence in play, excellence in work, excellence in agency, inner peace, relatedness, community, spirituality, happiness, creativity) were explored to identify overlapping constructs (appendix 2.7). Several meetings were held to review the similarities between the two models. A provisional matrix was created by the lead researcher to map the overlap between constructs. This was reviewed collaboratively and adaptations were made as discussion developed regarding the similarities between the models. When consensus regarding the overlap between constructs was established, the lead researcher created a list of potential items for the questionnaire.

The initial measure contained 20 items. The field supervisors offered advice based on their clinical expertise in relation to the language used and relevant items for inclusion. It was collectively decided to include items under the construct 'hope and optimism' (e.g. motivation) although this did not match directly on to a primary good as all involved believed this was in keeping with the principles of the model. Although there were no constructs explicitly related to risk, two additional items were included in the questionnaire, based on the advice of the field supervisors. This decision was made because reduction of risk is a key aim of the GLM and risk items were deemed necessary in order to make the questionnaire relevant to a forensic population. It was decided collaboratively to break down each item into two components as all researchers involved thought it was important to firstly establish what values are personally salient to the individual completing the questionnaire before enquiring about their level of satisfaction with that value. Initially some items were phrased "X is important to me" whilst others were phrased "I value X". In order to make it clear that the scale was assessing the importance of personal values the wording of all items were changed to reflect this.

When agreement was reached regarding items for inclusion the questionnaire was finalised and titled SAFER - The Scale for Assessing the Forensic Experience of

Recovery (appendix 2.8). The final version of the questionnaire contains 24 statements each with two components. The first component, designed to identify values reflective of the constructs identified through the process of exploring the connections between CHIME and GLM primary goods asks if the respondent values a particular experience and requires a yes or no answer which is subsequently scored 0 or 1. The second component, designed to assess satisfaction in the achievement of values identified as important to the respondent requires the respondent to indicate the extent to which they are currently living in a way which is consistent with the value. Responses range from “not at all” to “very much” and are rated on a three point scale. The scoring criteria for the second component of the questionnaire were developed in line with the scoring format of other validated measures of recovery, for example, I.ROC.

The SAFER was shared with the Department of Forensic Mental Health and Learning Disability NHS Greater Glasgow & Clyde (GGC) Research and Audit Committee and the Research and Development Department at the State Hospital. No recommendations were received from the committees in relation to the design or content of the SAFER.

Procedures: RMOs and senior charge nurses from low, medium and high secure hospitals (N=3) were contacted to request permission to recruit (appendix 2.9) and asked to distribute patient information sheets (appendix 2.10). Patients were given at least 24 hours to consider participating. The researcher contacted each site to enquire about interest and arranged to meet potential participants.

The researcher obtained informed consent (appendix 2.11) and met with participants to complete the SAFER, I.ROC, RAS, QPR and PAM. Administration of the SAFER was repeated after two weeks. The researcher read all questionnaires aloud and participants provided a verbal response. It took between 60 minutes and 90 minutes to complete. Participants were offered a break and most participants completed the measures in two to

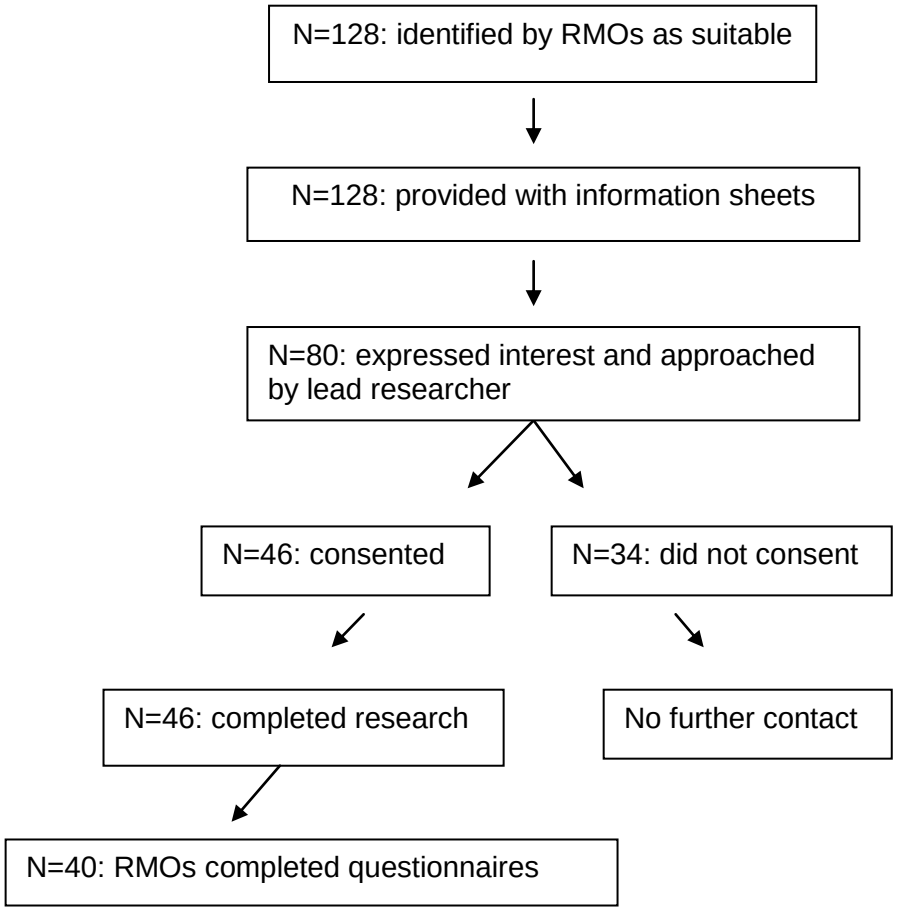
three sessions. In order to obtain qualitative information about participants' perception of the questionnaire they were asked: "What did you like about the questionnaire?", "What did you dislike about the questionnaire?", "Is there anything you would change?" RMOs and General Practitioners (GP) were informed of participation (appendix 2.12). RMOs were asked to complete the Dundrum-4.

Ethical and management approval: The research proposal (appendix 2.13) was submitted to the Department of Forensic Mental Health and Learning Disability NHS Greater Glasgow & Clyde (GGC) Research and Audit Committee and the Research and Development Department at the State Hospital. It was submitted to NHSGGC Research and Development Department and to the West of Scotland Research Ethics Committee (14/WS/1099). Approval was received following minor amendments (appendix 2.14).

Results

Sample characteristics: Forty six participants were recruited. 98% were male (N=45), and mean age was 42 years (range 23-66 years). Half the sample (N=23) were from a high secure hospital, 26% (N=12) from a medium secure hospital and 24% (N=11) from a low secure hospital. 15% (N=7) were residing within a secure learning disability setting. Psychiatric diagnoses were not recorded. There was 0% attrition rate.

Figure 3: Recruitment flow chart



Data Analysis: Table 8 displays mean total scores for the SAFER value scale (part A) and experience scale (part B). Table 9 displays average scores for each item of the SAFER.

Table 8: SAFER Total scores

SAFER	Mean	Median	Standard deviation	Interquartile range
Part A time point one	22.43	23	2.10	21-24
Part A time point 2	22.43	24	2.60	22-24
Part B time point 1	48.3	50	14.5	38-61
Part B time point 2	49.3	52	14.8	39-61

Table 9: SAFER individual item scores

SAFER Item	No participants who endorsed this item as important to them	Mean score for experience related to value (range 0-3)	Standard Deviation	α if item removed
Close relationships with family & friends	46	2.3	0.93	0.92
Repair difficult relationships	43	1.8	1.05	0.92
Build new relationships	44	2.2	0.93	0.91
Support from patients	34	1.4	1.17	0.92
Being part of community	42	1.5	1.11	0.91
Hope for future	44	2.4	0.86	0.92
Others optimistic about future	43	2.1	1.04	0.92
Things to look forward to	45	2.5	0.81	0.92
Motivation to make changes	43	2.3	0.98	0.92
Being person I am	44	2.2	0.99	0.92
Confidence	43	2.0	0.99	0.91
Others accepting mental health difficulties	42	2.1	0.98	0.91
Purpose to life	45	2.2	0.84	0.92
Healthy lifestyle	43	2.0	1.04	0.92

SAFER Item	No participants who endorsed this item as important to them	Mean score for experience related to value (range 0-3)	Standard Deviation	α if item removed
Happiness in life	46	2.0	0.98	0.91
Role in community	40	1.5	1.22	0.92
Understanding of mental health	43	2.4	0.93	0.92
Control over life	43	1.7	1.12	0.92
Choices about care & treatment	46	2.1	1.05	0.92
Responsibility	45	2.1	1.12	0.92
People focus on things I do well	45	2.1	0.92	0.91
Being able to express myself	46	2.0	0.86	0.91
Others open about risk	43	2.0	1.13	0.92
Talking to others about risk	34	1.8	1.26	0.92

Table 10: Total scores for all measures completed

Measure	Mean	Median	Standard deviation	Interquartile range
I.ROC	52.4	53.6	9.4	22-69
RAS	166.5	165.5	15.4	137-198
QPR Intrapersonal Subscale	51.5	51	6.6	38-66
QPR Interpersonal Subscale	14.5	15	3.0	7-20
PAM Anxious Subscale	0.85	0.75	0.62	0 - 2.6
PAM Avoidance Subscale	1.29	1.25	0.49	0.25- 2.5
Dundrum-4	12.95	13	4.33	2 – 21

To obtain scores reflective of both components of the SAFER the following calculations were made - total score SAFER-part B divided by number of items endorsed (total score SAFER-part A). The mean total score of SAFER-part B divided by number of items endorsed at time point one was 2.1 with a standard deviation of 0.56 and at time point two was 2.2 with standard deviation 0.55.

SAFER scores were normally distributed at time point one, $D(46) = .10$ ($p>.05$); and time point two, $D(46) = .09$ ($p>.05$). Scores were normally distributed for the I.ROC, $D(46) = .08$ ($p>.05$); the RAS, $D(46) = .10$ ($p>.05$), the QPR intrapersonal subscale, $D(46) = .10$ ($p>.05$), and interpersonal subscale, $D(46) = .14$ ($p>.05$), the PAM avoidance subscale, $D(46) = .08$, ($p>.05$) and anxiety subscale, $D(46) = .13$, ($p>.05$), and the Dundrum-4, $D(46) = .10$, ($p>.05$).

Concurrent validity: Correlations between the SAFER and I.ROC, RAS, QPR and Dundrum-4 were evaluated using Pearson correlation coefficient. There was a large positive correlation between the SAFER and the I.ROC, *r*=.50, N=46, (p<.05); and the QPR intrapersonal subscale, *r*=.62, N=46, (p<.05). No significant association was found between the SAFER and the QPR interpersonal subscale, *r*=.27, N=46, (p>.05). There was a moderate positive correlation between the SAFER and the RAS, *r*=.37, N=46, (p<.05). No significant correlation was found between the SAFER and the Dundrum-4, *r*=-.10, N=40, (P>.05). The null hypothesis that there will be no correlation between these measures was accepted.

Test-Retest Reliability: Correlations between SAFER scores collected at two time points were evaluated using Pearson correlation coefficient. As predicted there was a strong positive correlation between scores collected two weeks apart, *r*=.79, N=46, (p<.05), indicating good test-retest reliability.

Internal consistency: Cronbach's alpha was used to evaluate internal consistency and results indicated the SAFER has good internal consistency (α=.92, 95% CI = .88, .95).

Recovery and Attachment: The relationship between recovery and attachment was evaluated using Pearson correlation coefficient. As hypothesised, there was a moderate correlation between the SAFER and the PAM avoidance subscale, *r*= -.49, N=46, (p<.05), suggesting a negative relationship between avoidant attachment style and recovery. There was no significant association between the SAFER and PAM anxiety subscale *r*=.00, N=46, (p>0.5).

Sensitivity analysis: Participants reported that some items were not clear and were open to misinterpretation (N=14 participants). In particular item 23 (I value other people being

open about risk) and item 24 (I value talking to other people about risk). Participants requested clarity on the term risk i.e. risk of reoffending and/or deterioration in mental health and who the term 'others' referred to e.g. staff or patients. Post-hoc sensitivity analysis was conducted on the scale when these items were removed and there were no changes in the patterns of correlations (appendix 2.15).

A further sensitivity analysis was conducted to evaluate whether missing data from psychiatrists (N=6) was associated with any differences in the participant population (appendix 2.16). There were no significant differences identified in relation to age or scores on the SAFER, I.ROC, RAS, QPR (intra and interpersonal subscales) and PAM (avoidance subscale). Differences were identified between scores on the PAM anxiety subscale.

Feedback from participants: Some participants thought the questionnaire was difficult to understand (N=6) and a minority expressed concern about answering correctly or thinking there might be a hidden meaning (N=2). The majority of participants did not have difficulty understanding and several commented that the questionnaire was easy (N=9) and direct (N=7). There was a mixture of comments about the format with some saying they liked the variety of the yes/no response to part A and the scaled response to part B, whilst other said they would have preferred one answering style. A number of people liked that there was not an 'I don't know' response whilst others thought there should be room for grey areas.

There were many positive comments about the questionnaire being interesting, positive and client focused. Participants liked that it focused on their values and several reported that it contained items that were personally salient and relevant to their recovery (N=15). A smaller number of participants expressed that they liked that it showed that other people are interested in their values, perspective and recovery (N=4). Particular items reported as

positive included those related to family, responsibility, choice, motivation, hope, support from other patients and others acceptance of mental illness. A large number of participants commented that it made them think (N=18). They referred to various things it made them think about e.g. how they feel about people, the support they have, how they are perceived by others, their values, recovery and their future, what is missing from their recovery, how much they understand their mental health and interactions with professionals. In terms of the emotional impact of the questionnaire, it was positively perceived by several participants who said it made them reflect on their values and the level of support and opportunities available. A smaller number said it made them reflect on their restrictions e.g. feeling isolated from their community, not having enough responsibility and choice.

There were suggestions on how to improve the questionnaire. The main suggestion being to reword items 23 and 24 to improve clarity. Two participants suggested that item 1 (I value close relationships with family and friends) should be split into two separate items, one for family and one for friends. It was suggested to include space under each item to allow the participant to explain the rationale for their answer.

Discussion

The aim of the research was to develop a self-report measure of recovery for use in forensic mental health which incorporates the principles of CHIME and the GLM. A measure, conceptually based on these models of recovery and offender rehabilitation, was developed through identification of overlapping constructs – the SAFER. In order to evaluate the psychometric properties of the SAFER and explore its acceptability to the intended population, a cross-sectional pilot study was conducted with 46 participants from low, medium and high secure forensic hospitals. Prior to completing the study it was hypothesised that the SAFER would correlate with other validated measures of recovery,

that it would have good test-retest reliability and internal consistency. It was also hypothesised that there would be a correlation between anxious and avoidance attachment styles and recovery as measured by the SAFER.

Statistical analysis revealed that the SAFER significantly correlated with the I.ROC, RAS and QPR intrapersonal subscale. The SAFER had excellent test-retest reliability and internal consistency. There was a significant negative correlation between the SAFER and the PAM avoidance subscale. This indicates greater recovery scores were associated with less avoidant attachment styles. There were no significant associations between the SAFER and the QPR interpersonal subscale and PAM anxiety subscale. There was also no significant association between the SAFER and the Dundrum-4 indicating that service users' and doctors' perceptions of recovery were not significantly related. This could also be due to a difference in the way in which the two measures conceptualise recovery. The Dundrum-4 is used to inform decisions regarding appropriate level of therapeutic security and contains items more reflective of risk assessment than recovery. For example, items related to stability of psychiatric symptoms, leave entitlements, dynamic risk items and victim sensitivity. This is in contrast to the way in which recovery is conceptualised by the SAFER where items are designed to capture information related to personally salient values.

In terms of the acceptability of the SAFER, participants stated that the SAFER was interesting, positive, client focused and that items were personally salient and relevant to their recovery. Participants reported that it encouraged them to reflect on their values and recovery in a positive manner.

The SAFER was developed to address gaps in the research in relation to measuring recovery within forensic mental health settings from the perspective of the service user. It differs from other measures like the MHRM which was developed for general mental

health settings and later validated in forensic environments. The SAFER can be used as an outcome measure and as a means of facilitating discussion on patient values and goals for recovery. Feedback from participants indicated that the SAFER encouraged them to reflect on their values and recovery in a way which appeared novel to many participants. The SAFER has been updated to facilitate such discussion between service users and clinicians e.g. space under each item to record discourse (appendix 2.17). The study found no significant relationship between service users' and RMOs' perceptions of recovery which identifies the need to facilitate recovery focused conversations in order to develop a shared understanding of recovery based on an individual's values.

The SAFER is in keeping with the current ethos of the health service i.e. facilitating recovery focused and value based practice (Wallcraft et al., 2007). Incorporating principles of recovery such as choice, responsibility and autonomy can be difficult within forensic mental health where patients are detained and subject to mental health and/or criminal legislation (Turton et al., 2011). Despite the challenges it is important to incorporate a recovery approach within forensic mental health. The GLM proposes that through the development of value based goals offenders can work toward their recovery with the dual aim of improving wellbeing and reducing reoffending. Although the robustness of the evidence for the GLM is questionable (Quill, 2015), the principles are based on theoretically validated concepts of basic human needs and desires. The GLM reflects an important shift in forensic mental health towards the recognition of the benefits of value based, recovery focused practice.

Relatedness and connectedness are identified as important aspects of the process of recovery (Leamy et al., 2011). Within secure settings the relationship between service users and staff is part of this process (Barnao, Ward & Casey, 2015). The development of trust and honesty within these therapeutic relationships is potentially impacted upon by the nature of being detained and clinicians dual responsibility. Clinicians have a duty of

care to support offenders to improve their wellbeing but they must also assess, monitor and manage risk as they have a responsibility to keep the public safe from harm. Given the complex and co-morbid mental health and personality difficulties forensic mental health patients present with, they are likely to have difficulties developing therapeutic relationships due to insecure attachment styles and interpersonal functioning. There is evidence to suggest that insecure attachment styles are associated with poor engagement with services (Gumley et al., 2014). Campbell et al. (2014) found that in a sample of forensic inpatients avoidant attachment style was associated with negative perception of ward climate and service attachment. The current study found that recovery was associated with less avoidant attachment styles. Facilitation of recovery focused conversations, through the use of the SAFER, could be a way of fostering therapeutic relationships and promoting service attachment.

Strengths of the study: A full data set (0% attrition) was obtained, based on power calculations conducted *a priori* meaning the study had good power to detect hypothesised correlations. The SAFER was found to have concurrent validity with other validated measures of recovery, excellent test-retest reliability and internal consistency. Furthermore it appeared acceptable to the population for which it was developed. These preliminary findings offer promise for the utility of the measure in clinical practice across forensic mental health settings.

The heterogeneity of the sample is considered a strength at this stage in the development of the measure as it was useful to evaluate its acceptability to individuals of various abilities and at different points in their recovery. Within a forensic setting there tends to be heterogeneity suggesting the data set is representative of the population.

To the author's knowledge, there are no other self-report measures of recovery specifically developed for use in a forensic population which incorporate principles of

recovery and the GLM. There is another self-report measure of recovery currently being validated by the researchers of the Dundrum-4 (Davoren et al., 2013). This measure is likely to contain the same items as the clinician rated measure which is not as comprehensive in its assessment of recovery as the SAFER.

Post-hoc analysis was completed on the SAFER minus the last two items which specifically relate to forensic risk issues and the assumptions of validity and reliability were sustained. This indicates the measure could potentially be used beyond a forensic setting.

Limitations: This was a small scale pilot study that did not have sufficient power to conduct factor analysis.

The Dundrum-4 clinician rated recovery measure was not returned for every participant, although differences within the participant population for whom the Dundrum-4 was and was not returned were only evidence in one subscale of one measure. The difference between the conceptualisation of recovery in the Dundrum-4 and the SAFER could potentially have influenced the finding that doctors' and participants' perception of recovery did not correlate.

The SAFER was compared to recovery measures not validated in a forensic setting. The MHRM, a self-report recovery measure validated in forensic settings, was not used as a measure of concurrent validity because the systematic review of outcome measures suitable for forensic settings published by Shinkfield and Ogloff (2014) was discovered after the date of approval for the study.

Exploration of the cross cultural acceptability of the SAFER was beyond the scope of the study. Research indicates that culture can potentially impact upon values and perspective of recovery (Slade et al., 2012) and this may be a valuable area to evaluate as part of further development of the SAFER.

Certain characteristics of the sample were not recorded e.g. psychiatric diagnosis and length of stay in a forensic hospital, due to ethical issues concerning confidentially of a vulnerable client group. Further research may wish to consider associations between these factors and the SAFER.

The majority of participants in this study were male. This was expected as there are just ten female beds across the three hospitals sampled. Further research may wish to evaluate the SAFER with female offenders.

Some participants found the questionnaire difficult to understand and required minor adaptations, for example, re-wording or offering further explanation of items. This could potentially impact upon the validity of the findings. Those who needed adaptations to the SAFER were observed to also need adaptations on other recovery measures used in the study.

Implications for future research: In order to further explore the psychometric properties of the SAFER a larger sample size is needed. It would be of interest to conduct focus groups to obtain more qualitative feedback on participants' perceptions of the measure. It would also be of interest to explore the clinical predictability of the SAFER through evaluating its ability to measure change before and after a recovery focused intervention.

Conclusions: A self-report measure of recovery conceptually based on the Good Lives Model of offender rehabilitation and the CHIME model of recovery has been developed.

Results of this pilot study have demonstrated that the SAFER is a reliable and valid tool for use with participants in high, medium and low secure forensic facilities. Further research is necessary to obtain a larger dataset in order to confirm the validity of the measure. With further validation the SAFER could be a useful clinical tool to facilitate discussion on recovery, measure recovery, and evaluate the effectiveness of recovery focused and good lives interventions.

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Chapter 3: Advanced Clinical Practice 1
Reflective Account Abstract

Is psychological therapy for everyone? Knowing when therapy is inappropriate and potentially unhelpful

The BPS Code of Conduct and Ethics states psychologists have a responsibility to "terminate professional services when clients do not appear to be deriving benefit and are unlikely to do so" (p 20). In first year I found it hard to recognise this due to a belief that everyone can benefit from psychological therapy. I used Gibbs (1988) Reflective Model and Stoltenberg and McNeill's (2009) Integrated Developmental Model to reflect on my development of this competency. I realise that while my belief stems from compassion and a desire to alleviate distress it also places me in the rescuer role. As my self awareness and reflective capacity has developed, I am less likely to place myself in this position as I realise it will lead to burnout. Being a good practitioner means recognising when therapy is contraindicated. It can be more compassionate not to offer therapy if the client is not safe or motivated to engage. I realise I place a lot of responsibility on myself as the therapist and negatively evaluate my skills when a client does not engage. Through reflection I have been reminded that therapy is a collaborative process. I will continue to develop my competence in recognising when psychological therapy is not appropriate. This will benefit my practice and influence my functioning within multi-disciplinary teams and how I represent the profession. I realise that to convey to clients and colleagues that psychology is suitable for everyone would set up unrealistic expectations which could potentially lead to disappointment and disillusionment with the profession.

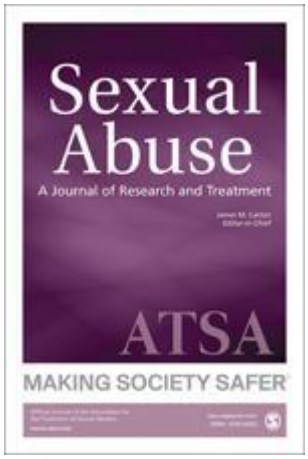
Chapter 4: Advanced Clinical Practice 2
Reflective Account Abstract

The role of psychology in multi-disciplinary teams

One of the aims of the doctorate training course is to prepare trainees for the various aspects of their role as a qualified clinical psychologist and to support the development of skills necessary for effective multi-disciplinary working. I have reflected on the role of psychology within multi-disciplinary teams, e.g. supervision, training, consultation, service evaluation and development. I have reflected on the necessity of good working relationships with colleagues to be able to carry out this role. I used Johns' Model of Structured Reflection to discuss two personal examples of multi-disciplinary working; one challenging and one positive experience. Both experiences were influenced by the quality of professional relationships and team dynamics. I considered the factors necessary to facilitate good working relationships, including joint understanding of and respect for different roles and previous experiences of collaborative working. It has been helpful to reflect upon these experiences before I move into my role as a qualified clinical psychologist within a multi-disciplinary team. As I move into this new role I will be mindful of team dynamics and will use supervision to formulate any potential ruptures to team functioning and consider how I can positively contribute to the system. I will make use of my interpersonal skills when forming new relationships. I will be transparent with colleagues about what my role involves and will show enthusiasm for my job and commitment to the team. I will model appropriate multi-disciplinary working and sharing of knowledge and skills in order to facilitate positive working relationships.

Chapter 5: Appendices

Appendix 1.1 Authors Guidelines for Submission



Sexual Abuse: A Journal of Research and Treatment

2014 Impact Factor: 2.113

2014 Ranking: 40/119 in Clinical Psychology

Description

Sexual Abuse: A Journal of Research and Treatment, the official journal of the Association for the Treatment of Sexual Abusers, provides a forum for the latest original research and scholarly reviews on both clinical and theoretical aspects of sexual abuse.

Unlike other publications that present a mix of articles on sexual abuse and human sexuality in general, *Sexual Abuse* is the only one to focus exclusively on this field, thoroughly investigating its aetiology, consequences, prevention, treatment and management strategies.

The in-depth studies provide essential data for those working in both clinical and academic environments, including psychologists, psychiatrists, social workers, and therapists/counsellors, as well as corrections officers and allied professionals in children's services.

Aims and scope

Sexual Abuse: A Journal of Research and Treatment, the official journal of the Association for the Treatment of Sexual Abusers, provides an international and multi-disciplinary forum for the latest research (quantitative or qualitative) and scholarly reviews on theoretical, clinical, and policy-relevant aspects of sexual abuse. The journal publishes rigorously peer-reviewed articles on the characteristics, aetiology, life course, prevention, assessment, treatment, management, and consequences of individuals who have perpetrated sexual abuse and those who are at risk of doing so. This research provides essential evidence for those working in mental health, criminal

justice, public policy, advocacy, and academic settings, including allied professionals working with those who have experienced sexual abuse.

Submission Guidelines

SAJRT uses an online submission and review platform. Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/sajrt. Authors will be required to set up an online account on the SAGE Track system powered by ScholarOne. From their account, a new submission can be initiated. Authors will be asked to provide the required information (author names and contact information, abstract, keywords, etc.) and to upload the "title page" and "main document" separately to ensure that the manuscript is ready for a blind review. The site contains links to an online user's guide (Get Help Now) for help navigating the site.

Note to submitting authors:

Manuscripts currently under review or submitted up to December 31, 2014, will be handled by the outgoing Editor in Chief, James Cantor, PhD (james_cantor@camh.net). Manuscripts submitted on or after January 1, 2015, will be handled by the incoming Editor in Chief, Michael Seto, PhD.

Submission of a manuscript implies a commitment by the author to publish in the journal, if the manuscript is accepted, and the editors assume that any manuscript submitted to *SAJRT* is not currently under consideration by any other journal. Manuscripts are subjected to blind peer review and require the author's name(s) and affiliation listed on a separate page. Any other identification, including any references in the manuscript, the notes, the title, and reference sections, should be removed from the paper and listed on separate pages. Accepted submissions must conform to the *Publication Manual of the American Psychological Association* (APA), 6th edition. Each submission should also include an abstract between 100 and 150 words and 4-5 keywords.

Appendix 1.2: Example of inter rater reliability

Barnett et al. (2013)

Selection Bias	Researcher	Independent Rater
Random sequence generation.	N/A – study not randomised	N/A –study not randomised
Allocation concealment.	N/A – study not randomised	N/A –study not randomised
Baseline characteristics	Difference in baseline characteristics and disproportionate number of individuals between groups not controlled for in analysis.	Difference in baseline characteristics e.g. overall level of dysfunction scores
Performance bias.		
Blinding of participants and personnel	N/A – retrospective study	N/A – retrospective study
Detection bias		
Blinding of outcome assessment	No information reported regarding blinding of researcher to group intervention.	No information reported regarding blinding of researcher to group intervention.
Attrition bias		
Incomplete outcome data	Sample only consisted of 41% of offenders who completed the intervention.	Dataset – 41% of completers thus limitation and source of bias
Reporting bias		
Selective reporting	Analyses were selective, based on subgroups and those who completed and thus not based on an intention to treat principle. Post-hoc evaluation (analysis of subgroup of participants who offended against children) likely to be subject to bias.	Multiple analysis completed
Other bias		
Other sources of bias.	Heterogeneity within literature Method of data collection	Lack of comparison to other studies Method of data collection
Overall risk of bias	High risk of bias	High risk of bias

Appendix 1.3: Risk of Bias

Authors	Selection Bias – random concealment, allocation concealment, baseline characteristics	Performance Bias	Detection Bias	Attrition Bias	Reporting Bias
Harkins et al. (2012)	High Risk of bias No random allocation Disproportionate number of individuals between groups not controlled for in analysis	High Risk of bias No blinding of participants and/ or staff	High Risk of bias No information reported regarding blinding of researcher to group intervention	High Risk of bias Attrition rates only available for subgroup	High Risk of bias Between group analysis completed on disproportionate number of participants
Barnett et al.(2014)	High risk of bias No random allocation Difference in baseline characteristics & disproportionate number between groups not controlled for in analysis	High Risk of bias No blinding of participants and/ or staff	High Risk of bias No information regarding blinding of researcher to group intervention	High Risk of bias Incomplete dataset: 41% of offenders who completed intervention	High Risk of bias Selective & post hoc analyses, use of subgroups - not based on an intention to treat principle
Willis and Grace (2008)	Unclear risk of bias Recidivists & non-recidivists matched for time at risk and static risk level. Differences in baseline characteristics controlled for in analysis.	High Risk of bias No control group so not possible to blind	Low risk of bias Researchers blind to outcome when rating release plans & good inter-rate reliability reported.	Unclear risk of bias File information missing for 17 participants leading to their exclusion	Low risk of bias Controlled for differences between groups in analysis thus reducing risk of reporting bias
Scoones et al. (2012)	Unclear risk of bias Recidivists & non recidivists matched for time at risk and static risk level. Lack of information on	High Risk of bias No control group so not possible to blind	Low risk of bias Researchers blind to outcome when rating release plans & good inter-rate reliability	Unclear risk of bias File information missing for 22 participants leading to their	High Risk of bias Little variation in scores – release planning integral part of programme

	baseline characteristics		reported.	exclusion	

Appendix 2.1: Authors Guidelines for Submission

Journal of Mental Health

2014 Impact Factor: 1.570
5 Year Impact Factor: 1.742
2014 Ranking: 66/119 in Clinical Psychology

Aims and Scope

The Journal of Mental Health is an international forum for the latest research in the mental health field. Reaching over 65 countries, the journal reports on the best in evidence-based practice around the world and provides a channel of communication between the many disciplines involved in mental health research and practice. The journal encourages multi-disciplinary research and welcomes contributions that have involved the users of mental health services.

The international editorial team are committed to seeking out excellent work from a range of sources and theoretical perspectives. The journal not only reflects current good practice but also aims to influence policy by reporting on innovations that challenge traditional ways of working. We are committed to publishing high-quality, thought-provoking work that will have a direct impact on service provision and clinical practice.

The Journal of Mental Health features original research papers on important developments in the treatment and care in the field of mental health. Theoretical papers, reviews and commentaries are also accepted if they contribute substantially to current knowledge.

Submissions All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at http://mc.manuscriptcentral.com/cjmh. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

Manuscripts will be dealt with by the Executive Editor. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process.

The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Word Count The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do not include the abstract, tables and references in this word count. However manuscripts are limited to a maximum of 4 tables and 2 figures.

Book Reviews All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscript Style Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts: The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest

should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content.

Keywords: Authors will be asked to submit key words with their article, one taken from the pick-list provided to specify subject of study, and at least one other of their own choice.

Text: Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Keywords, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do not include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References: Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association, and all references listed must be mentioned in the text. Within the text references should be indicated by the author’s name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. Magnetic Resonance Imaging, 18, 351–355.

b) For books:

Powell, T.J. & Enright, S.J. (1990) Anxiety and Stress management. London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In

G.Parry & F. Watts (Eds.), A Handbook of Skills and Methods in Mental Health Research (pp. 75–89). London:Lawrence Erlbaum.

Illustrations: should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables: should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Proofs Page proofs are sent to the designated corresponding author. They must be carefully checked and returned within 48 hours of receipt. Please note that in the proof stage, only typographical errors, printer's errors and errors of scientific fact can be corrected. No substantial author's changes will be made.

Copyright It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Informa Healthcare. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms.

Appendix 2.2: I.ROC

I•ROC
QUESTIONNAIRE ANSWER SHEET

Name _____ Date _____

home

MENTAL HEALTH						
In the past 3 months… How often have you felt mentally & emotionally healthy, happy and well?	1	2	3	4	5	6
Notes						

LIFE SKILLS						
In the past 3 months… How often have you felt you have the skills you need to look after yourself?	1	2	3	4	5	6
Notes						

SAFETY & COMFORT						
In the past 3 months… How often have you felt safe and comfortable in and around your home?	1	2	3	4	5	6
Notes						

1	2	3	4	5	6
NEVER	ALMOST NEVER	SOMETIMES	OFTEN	MOST OF THE TIME	ALL THE TIME

hope

Norton Park, 57 Albion Road, Edinburgh, EH7 5QY | T 0131 475 2380 | E enquiries@penumbra.org.uk

I•ROC
QUESTIONNAIRE ANSWER SHEET

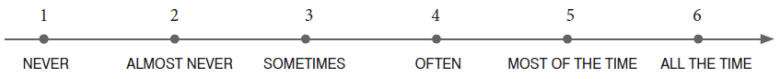
Name _____ Date _____

opportunity

PHYSICAL HEALTH						
In the past 3 months… How often have you felt physically healthy?	1	2	3	4	5	6
Notes						

EXERCISE & ACTIVITY						
In the past 3 months… How often would you say you have been active or exercised - on a regular basis?	1	2	3	4	5	6
Notes						

PURPOSE & DIRECTION						
In the past 3 months… How often would you say you have felt purposefully occupied?	1	2	3	4	5	6
Notes						



hope

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I•ROC
QUESTIONNAIRE ANSWER SHEET

Name _____ Date _____

people

PERSONAL NETWORK						
In the past 3 months… How often have you felt that you have people/friends/ loved ones who can support you if you need it?	1	2	3	4	5	6
Notes						

SOCIAL NETWORK						
In the past 3 months… How regularly have you taken part in community/ group activities?	1	2	3	4	5	6
Notes						

VALUING YOURSELF						
In the past 3 months… How often have you felt that you have been able to value and respect yourself?	1	2	3	4	5	6
Notes						

1	2	3	4	5	6
NEVER	ALMOST NEVER	SOMETIMES	OFTEN	MOST OF THE TIME	ALL THE TIME

hope

Norton Park, 57 Albion Road, Edinburgh, EH7 5QY | T 0131 475 2380 | E enquiries@penumbra.org.uk

I•ROC
QUESTIONNAIRE ANSWER SHEET

Name _____ Date _____

empowerment

PARTICIPATION & CONTROL						
In the past 3 months… How often have you felt involved in the decisions that affect your life?	1	2	3	4	5	6
Notes						

SELF-MANAGEMENT						
In the past 3 months… How often have you felt in control and able to manage your life?	1	2	3	4	5	6
Notes						

HOPE FOR THE FUTURE						
In the past 3 months… How often have you felt hopeful for the future?	1	2	3	4	5	6
Notes						

1 NEVER
2 ALMOST NEVER
3 SOMETIMES
4 OFTEN
5 MOST OF THE TIME
6 ALL THE TIME

Service user's signature _____ Service worker's signature _____

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Appendix 2.3: RAS

RECOVERY ASSESSMENT SCALE

I am going to read a list of statements that describe how people sometimes feel about themselves and their lives. Please listen carefully to each one and indicate the response that best describes the extent to which you agree or disagree with the statement. For each of these statements, please indicate whether you strongly disagree (1), disagree (2), not sure (3), agree (4), or strongly agree (5) with these statements.

+ **[Hand respondent scale card #32]**

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**	**NANS**	**NASK**
1. I have a desire to succeed.	1	2	3	4	5	8	9
2. I have my own plan for how to stay or become well.	1	2	3	4	5	8	9
3. I have goals in life that I want to reach.	1	2	3	4	5	8	9
4. I believe I can meet my current personal goals.	1	2	3	4	5	8	9
5. I have a purpose in life.	1	2	3	4	5	8	9
6. Even when I don't care about myself, other people do.	1	2	3	4	5	8	9
7. I understand how to control the symptoms of my mental illness.	1	2	3	4	5	8	9
8. I can handle it if I get sick again.	1	2	3	4	5	8	9
9. I can identify what triggers the symptoms of my mental illness.	1	2	3	4	5	8	9
10. I can help myself become better.	1	2	3	4	5	8	9

[INTERVIEWER: Scale continues on next page.]

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	NANS	NASK
11. Fear doesn't stop me from living the way I want to.	1	2	3	4	5	8	9
12. I know that there are mental health services that do help me.	1	2	3	4	5	8	9
13. There are things that I can do that help me deal with unwanted symptoms.	1	2	3	4	5	8	9
14. I can handle what happens in my life.	1	2	3	4	5	8	9
15. I like myself.	1	2	3	4	5	8	9
16. If people really knew me, they would like me.	1	2	3	4	5	8	9
17. I am a better person than before my experience with mental illness.	1	2	3	4	5	8	9
18. Although my symptoms may get worse, I know I can handle it.	1	2	3	4	5	8	9
19. If I keep trying, I will continue to get better.	1	2	3	4	5	8	9
20. I have an idea of who I want to become.	1	2	3	4	5	8	9
21. Things happen for a reason.	1	2	3	4	5	8	9
22. Something good will eventually happen.	1	2	3	4	5	8	9

[INTERVIEWER: Scale continues on next page.]

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	NANS	NASK
23. I am the person most responsible for my own improvement.	1	2	3	4	5	8	9
24. I'm hopeful about my future.	1	2	3	4	5	8	9
25. I continue to have new interests.	1	2	3	4	5	8	9
26. It is important to have fun.	1	2	3	4	5	8	9
27. Coping with my mental illness is no longer the main focus of my life.	1	2	3	4	5	8	9
28. My symptoms interfere less and less with my life.	1	2	3	4	5	8	9
29. My symptoms seem to be a problem for shorter periods of time each time they occur.	1	2	3	4	5	8	9
30. I know when to ask for help.	1	2	3	4	5	8	9
31. I am willing to ask for help.	1	2	3	4	5	8	9
32. I ask for help, when I need it.	1	2	3	4	5	8	9
33. Being able to work is important to me.	1	2	3	4	5	8	9
34. I know what helps me get better.	1	2	3	4	5	8	9

[INTERVIEWER: Scale continues on next page

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	NANS	NASK
35. I can learn from my mistakes.	1	2	3	4	5	8	9
36. I can handle stress.	1	2	3	4	5	8	9
37. I have people I can count on.	1	2	3	4	5	8	9
38. I can identify the early warning signs of becoming sick.	1	2	3	4	5	8	9
39. Even when I don't believe in myself, other people do.	1	2	3	4	5	8	9
40. It is important to have a variety of friends.	1	2	3	4	5	8	9
41. It is important to have healthy habits.	1	2	3	4	5	8	9

Appendix 2.4:

The Process of Recovery Questionnaire (QPR)

We developed this questionnaire in order to understand more about the process of recovery; what's helpful and what's not so helpful.

Everyone is different and there will be differences for everyone. The items on this questionnaire were developed through a process of interviewing service users about their recovery journeys. We hope that by filing in this questionnaire you will help us find out information that is important to you and your own recovery. Not all factors will be important to you, since everyone is different. This questionnaire is not intended to be used to impose anything against your wishes.

If you would like to fill in the questionnaire, please take a moment to consider and sum up how things stand for you at the present time, in particular over the last 7 days, with regards to your mental health and recovery. Please respond to the following statements by putting a tick in the box which best describes your experience.

	Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree Strongly
´ I feel better about myself					
2 I feel able to take chances in life					
3 I am able to develop positive relationships with other people					
4 I feel part of society rather than isolated					
5 I am able to assert myself					
6 I feel that my life has a purpose					
7 My experiences have changed me for the better					
8 I have been able to come to terms with things that have happened to me in the past and move on with my life					
9 I am basically strongly motivated to get better					
´ I can recognise the positive things I have done					
´ I am able to understand myself better					
´ I can take charge of my life					
´ I am able to access independent support					
´ I can weigh up the pros and cons of psychiatric treatment					
´ I feel my experiences have made me more sensitive towards others					

´	Meeting people who have had similar experiences makes me feel better					
´	My recovery has helped challenge other peoples views about getting better					
´	I am able to make sense of my distressing experiences					
´	I can actively engage with life					
¿	I realise that the views of some mental health professionals is not the only way of looking at things					
¿	I can take control of aspects of my life					
¿	I can find the time to do the things I enjoy					

Thank you for completing this questionnaire

Appendix 2.5: Dundrum 4

DUNDRUM-4: RECOVERY ITEMS

Recovery Item 1: Stability

The decision to move a person from high to medium security, or from medium to low (minimum) security, or from low to community or open placements, and eventually to recommend an absolute discharge may be critically influenced by the extent to which the person has been stable and predictable over time.

'Stability' here is negated by evidence of relapse of positive symptoms, or evidence of violence or threatened violence to others rating above 4/6 on the DASA or requiring de-escalation, restraint, seclusion, additional medication or enhanced nursing observations.

Coding: R1. Stability

0	Over a period of five years: no relapse or recurrence of problem behaviour, relapse unlikely; Advanced age may be taken into account
1	Relapses occur gradually over a period of weeks and in response to known patterns or precipitants. Signature signs and symptoms are known to carers and acknowledged by patient. Age may be taken into account.
2	Relapses may be abrupt, over days, but are predictable and patient has been stable for one year. Age may be taken into account.
3	Relapses may be abrupt and unpredictable, over days, but has been stable for one year.
4	Has no stable or predictable pattern of relapse of illness or recurrence of problem behaviours.

Information Quality: □ no information; □ staff observation; □ interview; □ family informants; □ clinical or police records (tick all informants that apply)

Recovery Item 2: Insight

The most practical definition of insight is that given by Amador and David – dividing the concept into three independent elements – recognition of one's own illness, recognition that one's own symptoms such as delusions and hallucinations are the products of illness and acceptance of the benefits to one's self of medication and other aspects of treatment.

The emphasis here is on appreciation that imparted information is relevant to the person himself or herself (note how the MacArthur structured professional judgement tools for assessing functional mental capacity divide this into understanding, reasoning and appreciation). Adherence or compliance is also relevant as evidence for the practical reliability of this quality.

Aspects of openness and trust are rated elsewhere.

Coding: R2. Insight

0	Over a period of five years: in the event of relapse, actively seeks help; cooperates with crisis contingency plans; has previously cooperated with relapse contingency plans; acknowledges own need for professional help and more general supports in maintaining recovery.
1	Realistic appraisal of own risk of relapse; practical approach to relapse prevention; family and friends, if involved, are aware and supportive; has previously cooperated with relapse contingency plans when necessary.
2	Accepts own legal obligations and accepts treatment; is encouraged to do so by those friends or family who are most influential with him/her.
3	Acknowledges own legal obligations as a minimum.
4	Does not accept any aspect of own illness; does not accept legal obligations; does not engage actively in treatment or recovery oriented programmes.

Information Quality: □ no information; □ staff observation; □ interview; □ family informants; □ clinical or police records (tick all informants that apply)

Recovery Item 3: Therapeutic Rapport

Working alliance and interpersonal trust are amongst the elements of therapeutic rapport. There is growing evidence that therapeutic rapport is one of the essential elements of meaningful outcome measurements for mental health. While this is commonly seen as a quality of the patient's attitude to the professional carers, it has a reciprocal which is best described as the trust the professional carers feel for the patient. The patient's sense of working alliance and interpersonal trust are aspects of an enduring disposition which non-the-less is amenable to change over the medium term.

Coding: R3. Therapeutic Rapport

0	Over a period of five years: maintains contact regularly and spontaneously; is capable of transferring an open and communicative relationship from one professional to another at reasonable intervals.
1	Open and trusting with all members of multi-disciplinary team; capable of communicating matters relevant to risk; tolerates intrusion and restrictions on autonomy of treatment plan/ conditional discharge; not excessively dependent on particular individuals.
2	Capable of openness and trust with members of multi-disciplinary team; capable of limited exploration of current mental state as related to risk.
3	Tolerates daily intrusions and constrictions of therapeutic security; engages and participates in therapeutic and occupational programmes.
4	Does not tolerate monitoring or supervision – may seek to secrete, deceive or subvert. Negative disposition towards carers and professionals generally.

Information Quality: □ no information; □ staff observation; □ interview; □ family informants; □ clinical or police records (tick all that informants apply)

Recovery Item 4: Leave

The graded use of leave outside the secure perimeter is an important guide to the readiness for progression from one level of therapeutic security to the next. Leave is an essential part of the rehabilitation process and it is necessary to take 'therapeutic risks' to ensure that institutionalisation does not occur, or to remedy early signs of institutionalisation. Institutionalisation should not be confused with the negative or deficit state of schizophrenia, which is characterised by lack of motivation, poverty of thought and affective flattening. Institutionalisation is characterised by dependence on the routines of the hospital ward, loss of skills in the activities of daily living such as doing one's own laundry, shopping and cooking for oneself and others, tending to one's own living space and property, and knowledge of the outside world generally e.g. using modern coinage, public transport, dealing with official forms and offices. While this item is not a rating of institutionalisation or of negative symptoms, this item is included because the necessity of taking therapeutic risks when assessing suitability for leave is so central to the process of rehabilitation and recovery in a forensic setting.

Coding: R4. Leave

0	• For a period of at least five years has lived in the community and • has tolerated home visits and / or visits to place of work by members of the mental health team, both planned and unannounced.
1	Has used unaccompanied leave in the community for at least six months.
2	• Can use accompanied leave in the grounds of the medium secure hospital most of the time and • can use accompanied leave in the community with one member of staff • except when in relapse or when other indicators of risk are higher than usual.
3	• Can safely visit a medium secure setting prior to moving there from a high secure setting; • can use occasional leave to visit hospitals, family or other private venues • when accompanied by one member of staff.
4	• Represents such a high risk of absconding that can only leave a high secure setting under close the supervision of two or more member of staff.

Information Quality: □ no information; □ staff observation; □ interview; □ family informants; □ clinical or police records (tick all informants that apply)

Recovery Item 5: Dynamic Risk Items.

Modern SPJ instruments such as the HCR-20 'Clinical' or current items and the HCR-20 'Risk' or future items are combined as 'dynamic' indicators of change over time. The S-RAMM, START and SAPROF may also describe these risk factors which are amenable to change. The HCR-20 'Risk' or future items are usually rated for the eventuality of remaining in their present placement ('in') or moving to a less secure or open / community placement ('out'). In general, if there is an obvious difference in the ratings for 'in' and 'out' then a move to a less secure place would increase the risk of violence.

As for Item T7, the rating for this item is not based on artificial actuarially calculated scores and probabilities. Instead the ratings are based on profiles of change over time.

Coding: R5. Dynamic Risk Items

0	If the dynamic items have remained low and stable for a period of five years, and the Current / present items are similarly stable and low, the transition from conditional discharge in the community to absolute discharge may be considered. It may be that this can only safely be accomplished where there is consistent evidence of remission of symptoms (e.g. HCR-20 C3 =0 or Andreasen criteria for remission).
1	As for '2', and - The dynamic scores should be equally low 'in' and 'out', while negative attitudes (HCR-20 C2) and impulsivity (C4) particularly would inhibit such a move. Active symptoms (C3), if they remain should be much reduced and stabilised. See R3 'Rapport' regarding insight.(C1). Plans lack feasibility (R1) should be regarded as particularly important.
2	The move from medium to low therapeutic security may increase exposure to destabilisers (R2) and certain types of stress (R5), if so this should inhibit such a move while these issues are dealt with either through further psychological treatment, through addressing the choice of setting or level of support to be provided on moving etc;
3	• There is a score of '8' or more on 'C' items,
4	• There is a score of '8' or more on 'R' items for a move from present level of security to the proposed next lowest level, OR • There is a substantial difference (4 or more) between the 'in' and 'out' scores for 'risk/future' items (R1 to R5), when computed for any move to a lower level of security than the current placement. • C2 negative attitudes may also be particularly relevant here.

Recovery Item 6: Victim Sensitivity Items.

This item presents special problems in balancing the rights and expectations of victims and patients. As a minimum, there should be a requirement that no fear or distress is afforded to the reasonable former victim or surviving relative of the victim. Some communities may be welcoming to the return of the patient, but some may not. If this were to engender a media campaign it would not be in the interests of the patient. An unsuccessful return to the former home community would have serious consequences for the future recovery of the patient. Accordingly, an essential part of the recovery process is the extent to which the needs of victims or their surviving relatives can be assessed and accommodated. This may be done by members of one of the other multi-disciplinary teams and/or a specialist victim support service making contact and offering information, support and advice, while avoiding breeching confidentiality. The needs of the victims can be incorporated into treatment and management plans, and conditions for leave and discharge. A continuing preoccupation with the former victim or with a predictable category of victim should also be rated here.

Coding: R6. Victim Sensitivity Items

0	• Patient is capable of remorse for harm done to the victim and victim's relatives and • Victim or survivors have not been actively involved for 5 years (or are reconciled) and • Media interest has not been active for five years and patient has been living anonymously in the community and
1	• Patient accepts and complies with conditions regarding non-contact with victim or surviving relatives of victim or category of victims as appropriate or • Victim or survivors can be accommodated by reasonable conditions and restrictions on the movements of the patient and these have been observed by the patient while on leave from the hospital or • Victim or survivors would not be upset by patient being in community, includes geographic exclusions to prevent accidental meeting or

	• Media interest is no longer likely and patient should be able to live anonymously in the proposed community location for discharge..
2	• Patient is capable of recognising the potential for hurt to the victim or category of victims. If at liberty would not represent a threat to them or • Victim or survivors can be accommodated by reasonable conditions and restrictions on the movements of the patient outside the hospital e.g. exclusion zones or • Victim would not be at risk of harm if patient was at liberty or • Media interest is no longer likely.
3	• Patient's preoccupation with specific victim or category of victims is encapsulated and no longer pervasive. • Victim or survivors are engaged in a process of liaison which respects confidentiality and the needs of both victim and patient, or • Victim or survivors would be upset / traumatised by contact but lesser harm original offence even if patient was in community or • Media interest is no longer active or intrusive but would still be hostile.
4	• Patient remains deluded or preoccupied with a former victim or category of victim and is still affectively motivated (e.g. angry, fearful) or • Victim or survivors remain actively engaged in petitioning against the movement of the patient or increase in access to the community or • Victim would be at risk of serious harm again if patient at liberty or • Media interest remains active, stigmatising and would pose a risk to the patient.

Information Quality: □ no information; □ staff observation; □ interview; □ family informants; □ clinical or police records (tick all informants that apply)

Appendix 2.6: PAM

PAM self-report

We all differ in how we relate to other people. This questionnaire lists different thoughts, feelings and ways of behaving in relationships with others. Thinking generally about how you relate to other key people in your life, please use a tick to show how much each statement is like you. Key people could include family members, friends, partner or mental health workers.

There are no right or wrong answers

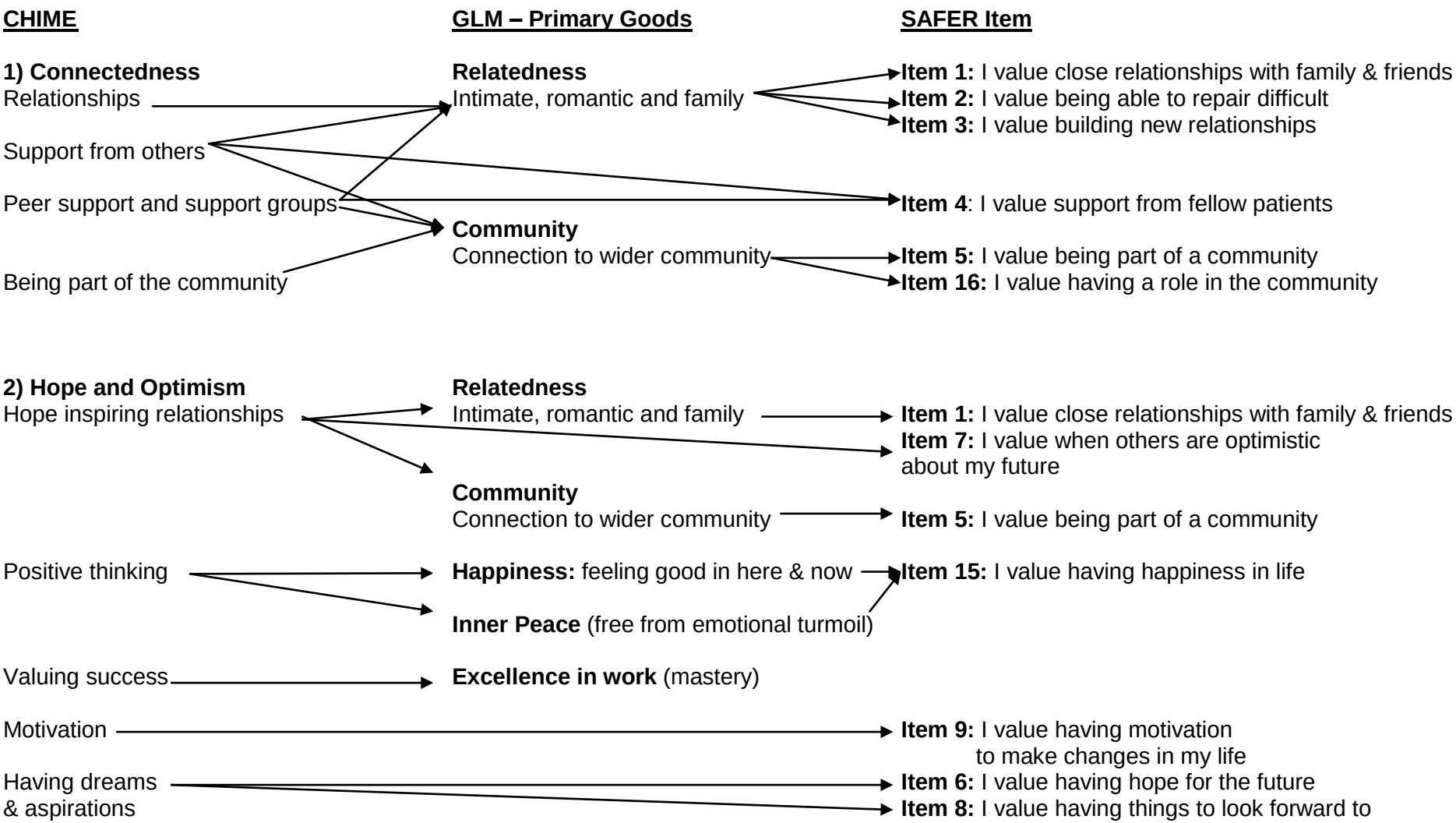
	Not at all	**A little**	**Quite a bit**	**Very much**
1. I prefer not to let other people know my 'true' thoughts and feelings.	(.0.)	(.1.)	(.2.)	(.3.)
2. I find it easy to depend on other people for support with problems or difficult situations.	(.3.)	(.2.)	(.1.)	(.0.)
3. I tend to get upset, anxious or angry if other people are not there when I need them.	(.0.)	(.1.)	(.2.)	(.3.)
4. I usually discuss my problems and concerns with other people.	(.3.)	(.2.)	(.1.)	(.0.)
5. I worry that key people in my life won't be around in the future.	(.0.)	(.1.)	(.2.)	(.3.)
6. I ask other people to reassure me that they care about me.	(.0.)	(.1.)	(2.)	(.3.)
7. If other people disapprove of something I do, I get very upset.	(.0.)	(.1.)	(.2.)	(.3.)
8. I find it difficult to accept help from other people when I have problems or difficulties.	(.0.)	(.1.)	(.2.)	(.3.)
9. It helps to turn to other people when I'm stressed.	(.3.)	(.2.)	(.1.)	(.0.)

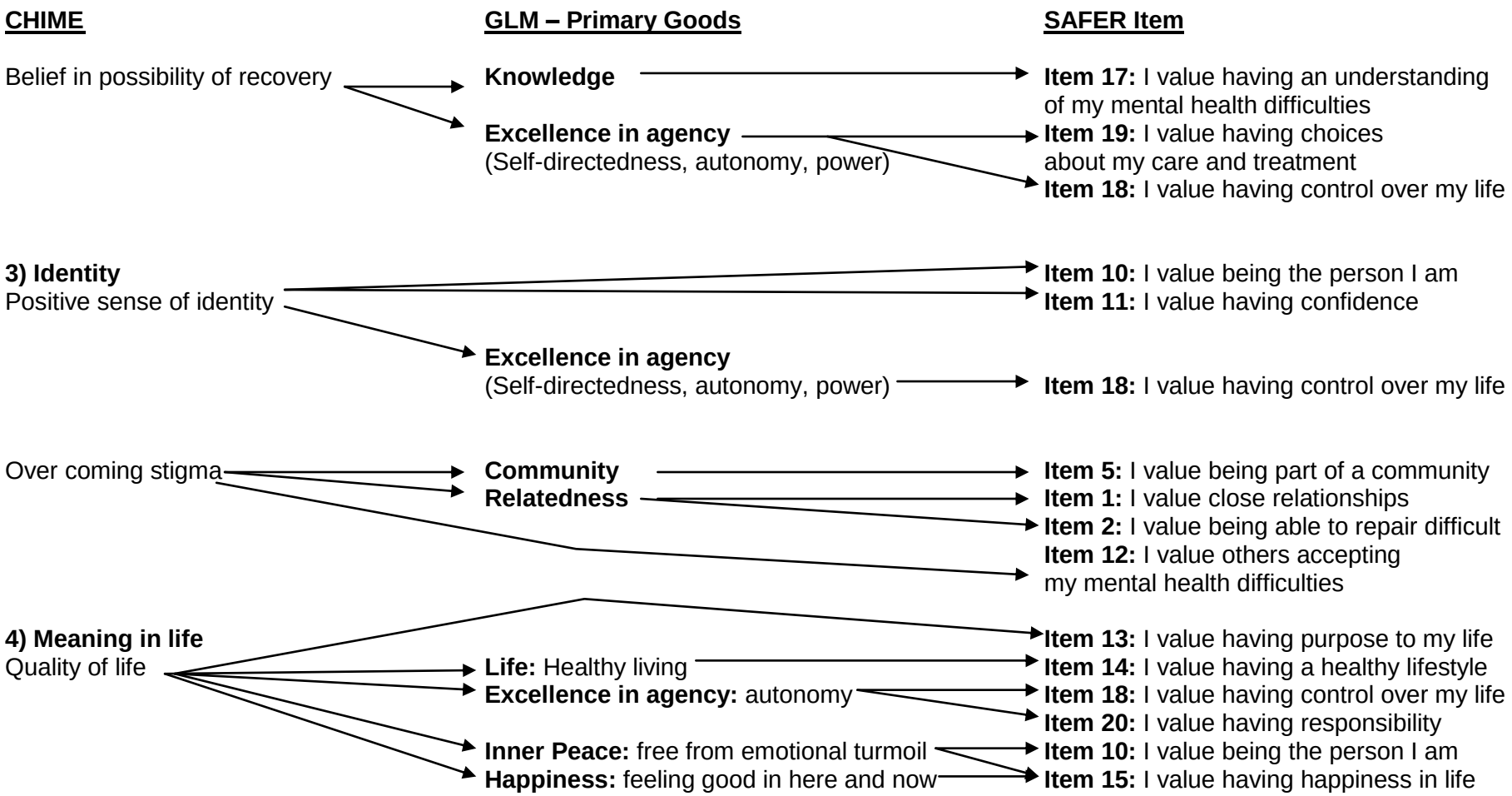
	Not at all	A little	Quite a bit	Very much
10. I worry that if other people get to know me better, they won't like me.	(.0.)	(.1.)	(.2.)	(.3.)
11. When I'm feeling stressed, I prefer being on my own to being in the company of other people.	(.0.)	(.1.)	(.2.)	(.3.)
12. I worry a lot about my relationships with other people.	(.0.)	(.1.)	(.2.)	(.3.)
13. I try to cope with stressful situations on my own.	(.0.)	(.1.)	(.2.)	(.3.)
14. I worry that if I displease other people, they won't want to know me anymore.	(.0.)	(.1.)	(.2.)	(.3.)
15. I worry about having to cope with problems and difficult situations on my own.	(.0.)	(.1.)	(.2.)	(.3.)
16. I feel uncomfortable when other people want to get to know me better.	(.0.)	(.1.)	(.2.)	(.3.)

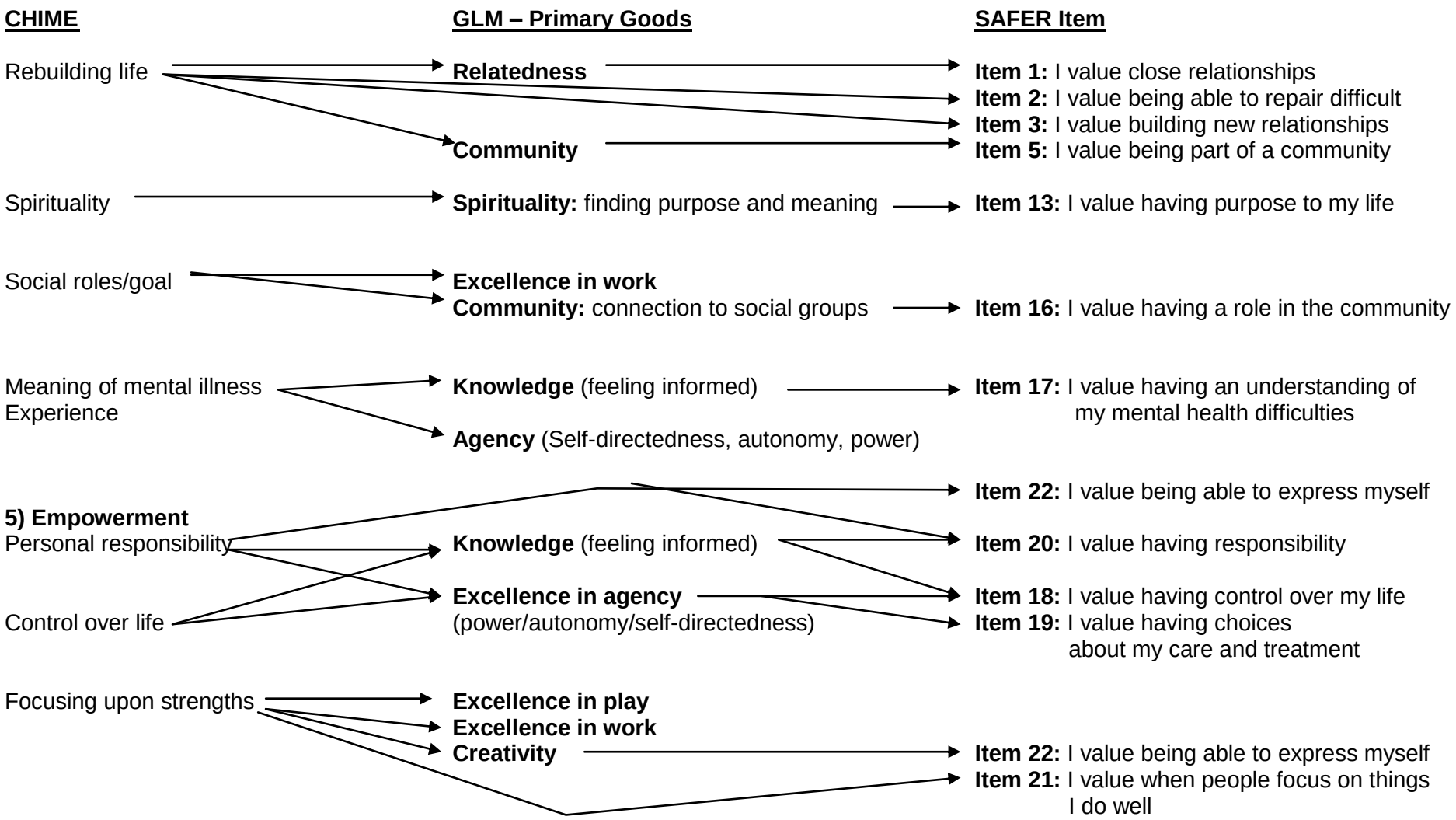
Appendix 2.7: Conceptual development of SAFER

CHIME Recovery processes	**Good Lives Model** Primary goods
Connectedness Peer support and support groups Relationships Support from others Being part of the community **Hope and Optimism about the future** Belief in possibility of recovery Motivation to change Hope inspiring relationships Positive thinking and valuing success Having dreams and aspirations **Identity** Dimensions of identify Rebuilding/ redefining positive sense of identity Overcoming stigma **Meaning in Life** Meaning of mental illness experience Spirituality Quality of life Meaningful life and social roles Meaningful life and social goals Rebuilding life	**Life** Healthy living Optimal physical functioning Sexual satisfaction **Knowledge** How well informed one feels about things that are important to them **Excellence in play** Hobbies and recreational pursuits **Excellence in work** Mastery experiences **Excellence in agency** Autonomy Power Self-directedness **Inner peace** Freedom from emotional turmoil and distress **Relatedness** Intimate, romantic & family relationships

Empowerment Personal responsibility Control over life Focusing upon strengths	**Community** Connection to wider social groups **Spirituality** In a broad sense of finding meaning and purpose in life **Happiness/pleasure** Feeling good in the here and now **Creativity** Expressing oneself through alternative forms


CHIME
GLM – Primary Goods
SAFER Item
1) Connectedness
Relationships
Support from others
Peer support and support groups
Being part of the community
Relatedness
Intimate, romantic and family
Community
Connection to wider community
Item 1: I value close relationships with family & friends
Item 2: I value being able to repair difficult
Item 3: I value building new relationships
Item 4: I value support from fellow patients
Item 5: I value being part of a community
Item 16: I value having a role in the community
2) Hope and Optimism
Hope inspiring relationships
Positive thinking
Valuing success
Motivation
Having dreams
& aspirations
Relatedness
Intimate, romantic and family
Community
Connection to wider community
Happiness: feeling good in here & now
Inner Peace (free from emotional turmoil)
Excellence in work (mastery)
Item 1: I value close relationships with family & friends
Item 7: I value when others are optimistic about my future
Item 5: I value being part of a community
Item 15: I value having happiness in life
Item 9: I value having motivation to make changes in my life
Item 6: I value having hope for the future
Item 8: I value having things to look forward to


CHIME
GLM – Primary Goods
SAFER Item
Belief in possibility of recovery
Knowledge
Item 17: I value having an understanding of my mental health difficulties
Excellence in agency
(Self-directedness, autonomy, power)
Item 19: I value having choices about my care and treatment
Item 18: I value having control over my life
3) Identity
Positive sense of identity
Item 10: I value being the person I am
Item 11: I value having confidence
Excellence in agency
(Self-directedness, autonomy, power)
Item 18: I value having control over my life
Over coming stigma
Community
Relatedness
Item 5: I value being part of a community
Item 1: I value close relationships
Item 2: I value being able to repair difficult
Item 12: I value others accepting my mental health difficulties
4) Meaning in life
Quality of life
Item 13: I value having purpose to my life
Life: Healthy living
Item 14: I value having a healthy lifestyle
Excellence in agency: autonomy
Item 18: I value having control over my life
Item 20: I value having responsibility
Inner Peace: free from emotional turmoil
Item 10: I value being the person I am
Happiness: feeling good in here and now
Item 15: I value having happiness in life


CHIME
GLM – Primary Goods
SAFER Item
Rebuilding life
Relatedness
Item 1: I value close relationships
Item 2: I value being able to repair difficult
Item 3: I value building new relationships
Community
Item 5: I value being part of a community
Spirituality
Spirituality: finding purpose and meaning
Item 13: I value having purpose to my life
Social roles/goal
Excellence in work
Community: connection to social groups
Item 16: I value having a role in the community
Meaning of mental illness
Experience
Knowledge (feeling informed)
Item 17: I value having an understanding of my mental health difficulties
Agency (Self-directedness, autonomy, power)
5) Empowerment
Item 22: I value being able to express myself
Personal responsibility
Knowledge (feeling informed)
Item 20: I value having responsibility
Excellence in agency
(power/autonomy/self-directedness)
Item 18: I value having control over my life
Control over life
Item 19: I value having choices about my care and treatment
Focusing upon strengths
Excellence in play
Excellence in work
Creativity
Item 22: I value being able to express myself
Item 21: I value when people focus on things I do well

Appendix 2.8: SAFER: Scale for Assessing the Forensic Experience of Recovery Version number 1 Date 12.08.14

The following questionnaire contains 24 statements. Each statement has two parts. The first part asks if a value, activity or experience in your life is important to you. This requires a yes or no response. The second part asks you to rate the extent to which you feel you are currently living in a way that is consistent with that value. A value is something which you judge as being important and worthwhile in your life. Your values can motivate you to behave in a certain way or can influence how you live your life.

I will read the following statements aloud. Please try to answer each statement.
There are no right or wrong answers.

This value is important to me

1) I value close relationships with family and friends	**No**	**Yes**				
If yes: I feel I have close relationships with family and friends			**Not at all**	**A little**	**Moderately**	**Very much**
2) I value being able to repair difficult relationships	**No**	**Yes**				
If yes: I feel that I can repair difficult relationships.			**Not at all**	**A little**	**Moderately**	**Very much**
3) I value building new relationships	**No**	**Yes**				
If yes: I feel that I can build new relationships			**Not at all**	**A little**	**Moderately**	**Very much**
4) I value support from fellow patients	**No**	**Yes**				
If yes: I feel supported by fellow patients			**Not at all**	**A little**	**Moderately**	**Very much**
5) I value being part of a community	**No**	**Yes**				
If yes: I feel part of a community			**Not at all**	**A little**	**Moderately**	**Very much**
6) I value having hope for the future	**No**	**Yes**				

If yes: I feel hopeful for the future			**Not at all** **A little** **Moderately** **Very much**
7) I value when others are optimistic about my future	**No**	**Yes**	
If yes: I feel that others are optimistic for my future			**Not at all** **A little** **Moderately** **Very much**
8) I value having things to look forward to	**No**	**Yes**	
If yes: I feel that I have things to look forward to			**Not at all** **A little** **Moderately** **Very much**
9) I value having motivation to make changes in my life	**No**	**Yes**	
If yes: I feel motivated to make changes in my life			**Not at all** **A little** **Moderately** **Very much**
10) I value being the person I am	**No**	**Yes**	
If yes: I feel happy with the person I am			**Not at all** **A little** **Moderately** **Very much**
11) I value having confidence	**No**	**Yes**	
If yes: I feel confident			**Not at all** **A little** **Moderately** **Very much**
12) I value others accepting my mental health difficulties	**No**	**Yes**	
If yes: I feel that others accept my mental health difficulties			**Not at all** **A little** **Moderately** **Very much**
13) I value having purpose to my life	**No**	**Yes**	
If yes: I feel that I have purpose to my life			**Not at all** **A little** **Moderately** **Very much**

14) I value having a healthy lifestyle	**No**	**Yes**				
If yes: I feel I have a healthy lifestyle			**Not at all**	**A little**	**Moderately**	**Very much**
15) I value having happiness in life	**No**	**Yes**				
If yes: I feel happy			**Not at all**	**A little**	**Moderately**	**Very much**
16) I value having a role in the community in which I live	**No**	**Yes**				
If yes: I feel that I have a role in the community in which I live			**Not at all**	**A little**	**Moderately**	**Very much**
17) I value having an understanding of my mental health difficulties	**No**	**Yes**				
If yes: I feel that I understand my mental health difficulties			**Not at all**	**A little**	**Moderately**	**Very much**
18) I value having control over my life	**No**	**Yes**				
If yes: I feel I have control over my life			**Not at all**	**A little**	**Moderately**	**Very much**
19) I value having choices about my care and treatment	**No**	**Yes**				
If yes: I feel that I have choices about my care and treatment			**Not at all**	**A little**	**Moderately**	**Very much**
20) I value having responsibility	**No**	**Yes**				
If yes: I feel that I have enough responsibility			**Not at all**	**A little**	**Moderately**	**Very much**
21) I value when people focus on the things I do well	**No**	**Yes**				
If yes: I feel that people focus on the things I do well			**Not at all**	**A little**	**Moderately**	**Very much**

22) I value being able to express myself	**No**	**Yes**				
If yes: I feel that I can express myself			**Not at all**	**A little**	**Moderately**	**Very much**
23) I value other people being open about risk	**No**	**Yes**				
If yes: I feel that other people are open about risk			**Not at all**	**A little**	**Moderately**	**Very much**
24) I value talking to other people about risk	**No**	**Yes**				
If yes: I feel that I can talk to other people about risk			**Not at all**	**A little**	**Moderately**	**Very much**

Thank you for completing this questionnaire.

Your answers to the following questions will help us to improve the questionnaire.

SAFER: Scale for Assessing the Forensic Experience of Recovery

The purpose of this research is to evaluate how effective the SAFER questionnaire is at capturing your experience of recovery within a forensic setting. It would be really helpful if you could answer the following questions and tell us what you thought of the questionnaire. Your opinions are highly valued and will be taken into account when further developing and improving the questionnaire.

What did you like about the questionnaire?

What did you dislike about the questionnaire?

Is there anything you would change?

Thank you for answering these questions.

Appendix 2.9: Letter to RMO

Mental Health and Wellbeing
Institute of Health and Wellbeing
University of Glasgow
Gartnavel Royal Hospital
Academic Centre
University of Glasgow
Glasgow G12 0XH
e.quill.1@research.gla.ac.uk or emma.quill@ggc.scot.nhs.uk

Dear Dr……

I am writing to you to request permission to visit XX hub/ward in order to invite patients to participate in research that I am conducting.

I am a trainee on the Doctorate of Clinical Psychology programme at the University of Glasgow. I am a forensic aligned trainee and have completed a 10 month placement at Rowanbank Clinic. The research, described below, is being supervised by Professor Andrew Gumley, University of Glasgow, Dr Emma Drysdale, Consultant Clinical Psychologist at Douglas Inch Centre and Dr Heather Laithwaite, Consultant Clinical Psychologist at Rowanbank Clinic. Dr Natasha Purcell, Principal Clinical Psychologist at The State Hospital, is also involved in the project.

What is the research about?
This is a pilot study and is the first stage in the development of a self report measure of recovery suitable for use within forensic mental health settings. A recovery measure, conceptually based on the CHIME model of recovery and the Good Lives Model of offender rehabilitation, has been developed under supervision. This measure is called the Scale for Assessing the Forensic Experience of Recovery: SAFER. The measure contains 24 statements, each with two parts. The first part relates to a value, for example, 'I value close relationships with family and friends' and requires participants to indicate if the value is important to them with a yes or no answer. If the value is important, then participants are asked to indicate the extent to which they feel they are living in a way which is consistent with this value.

The aims of this pilot project are to establish if forensic inpatients can be recruited to engage in research to validate the SAFER questionnaire and to explore aspects of the psychometric properties of the measure. We aim to explore the concurrent validity, test-retest reliability and internal consistency of the measure.

The questionnaire and research proposal has been shared with the Research and Audit Committee from NHSGG&C Directorate of Forensic Mental Health and Learning Disability and with the Research and Development Department at the State Hospital. The study has also been approved by the NHS Research Ethics Service and by the Research and Development departments at NHS GG&C and the State Hospital, as this is a multicentre study.

Who is being asked to take part?
I would like to recruit participants from Leverndale Hospital, Rowanbank Clinic and the State Hospital. It is hoped that 46 participants will be recruited; 23 from high secure and 23 from medium/low secure settings.

Inclusion criteria: all male and female forensic mental health inpatients from medium/low and high secure settings. No minimum length of stay in an inpatient facility is required for inclusion purposes. Patients are required to speak English.

Exclusion criteria: Patients who do not have capacity to provide informed consent. I would ask that you please bring to my attention any such patients and they will not be approached to participate.

I ask that either you as RMO, the senior charge nurse or the clinical psychologist for the ward invite any potential participants to participate and provide them with the Participant Information Sheet enclosed.

What does the research involve?
I will arrange to meet those who agree to participate and will support them to complete the SAFER measure, the Individual Recovery Outcome Counter, the Recovery Assessment Scale and the Questionnaire about the Process of Recovery. This is to assess the concurrent validity of the SAFER measure against these already validated measures of recovery. Participants will also be asked to complete the Psychosis Attachment Measure as the research would like to explore the relationship between recovery and attachment style.

I will read the measures aloud and ask participants for their response verbally. The process will take approximately an hour to an hour and a half. Participants can take a break at any time but as a matter of course participants will be invited to take a break after 60 minutes. If necessary it can be arranged for measures to be completed over two sessions. I will meet with participants after two weeks to complete the SAFER measure again to assess the test retest reliability of the measure. This will take approximately 15-20 minutes.

In order to obtain qualitative information about participants' perception of the questionnaire they will be asked to answer three questions about the SAFER questionnaire: "What did you like about the questionnaire?"; "What did you dislike about the questionnaire?"; "Is there anything you would change?" They will only be asked these questions once and this will be after completing the questionnaire the first time.

As responsible medical officer you will be asked to complete a short questionnaire, the Dundrum-4 Recovery Measure, to assess the relationship between participants and clinicians perception of recovery. The Dundrum-4 is a clinician rated tool and is part of a structured professional judgement instrument for assessing the need for therapeutic security. The Dundrum 4 contains six items – stability, insight, therapeutic rapport, leave, dynamic risk items and victim sensitivity. Each item is rated on a 5 point scale.

What happens next?
Patients should be given at least 24 hours to consider participation after being provided with information about the project. Patients can of course take longer to decide and we understand that some people may need a week to consider participation. I will contact you after one week to enquire about patients who may be interested in the project.

After patients have been allowed time to consider their participation I can arrange to visit the ward to meet with interested parties. I will obtain informed consent and will support patients to complete the questionnaires. I will arrange to meet participants again after two weeks to complete the SAFER measure for a second time.

Should you wish to discuss the research in further detail please do not hesitate to contact me.

Yours sincerely,

Emma Quill
Trainee Clinical Psychologist

Professor Andrew Gumley
Chief Investigator

Dr Heather Laithwaite
Consultant Clinical Psychologist
Supervisor NHS GG&C

Dr Natasha Purcell
Principal Clinical Psychologist
Supervisor The State Hospital

Appendix 2.10: Participant Information Sheet

Developing a Scale for Assessing the Forensic Experience of Recovery: the SAFER questionnaire

Participant Information Sheet: Version 2.2: date 20/10/2014
You are invited to take part in a research study. This information sheet tells you why the research is being done and what taking part involves. Please read this information sheet carefully before you decide whether or not to take part. You should take at least 24 hours to decide whether to take part. Please feel free to take longer if you need to. Sometimes people need a week or more to decide whether or not to take part in research.

Who is doing the research?
My name is Emma Quill and I am a Clinical Psychology trainee. I am studying at the University of Glasgow and working in the NHS. I am supervised by Professor Andrew Gumley, at the University of Glasgow. I am also supervised by Dr Emma Drysdale, Consultant Clinical Psychologist at Douglas Inch Centre and Dr Heather Laithwaite, Consultant Clinical Psychologist at Rowanbank Clinic. Dr Natasha Purcell, Principal Clinical Psychologist at The State Hospital, is also involved in the project.

What is the research about?
The research is about learning more about people's experience of recovery in a forensic hospital. At the moment there is no widely used measure of recovery in forensic hospitals. We have developed a questionnaire about recovery. We want to know what people in forensic hospitals think about the questionnaire. We also want to know if the questionnaire is a good way of measuring recovery.

We are inviting patients from The State Hospital, Rowanbank Clinic and Leverndale Hospital to take part. We hope that 46 people will agree to take part.

This is a pilot study. It is the first stage of the research to develop this questionnaire. If we find that the questionnaire is a good way of measuring recovery there may be further research. You may be invited to take part again. You do not have to take part in any further research if you do not want.

What is involved?
If you want to take part in the research we will ask you to complete the questionnaire we developed. This is called the Scale for Assessing the Forensic Experience of Recovery (SAFER). We will ask you to complete four other questionnaires too. The reason for this is because we need to compare the SAFER to other recovery questionnaires. This is so we can make sure it is measuring what it is meant to measure. One of the measures is about attachment and how you get on with people. We want to see if this is related to recovery.

If you want to take part I will meet with you to complete these questionnaires. I will read the questionnaires and ask for your answer to each question. This will take between an hour and an hour and a half. You can take a break at any time and I will encourage you to take a break after an hour. If this is too long for you, even with a break, we can arrange to do the questionnaires in two appointments.

I will ask you three questions about the SAFER questionnaire. I will ask what you liked, what you disliked and anything you would change about the questionnaire.

I will meet with you again after two weeks to do the SAFER questionnaire again. This will take 15-20 minutes. This is to see if there is any difference in how people fill in the

questionnaire over time. You do not need to complete the other questionnaires again or answer any other questions.

If you agree to take part your psychiatrist will be asked to complete a recovery measure. We will need your consent for this.

Do I have to take part?
No, you do not have to take part. If you take part but change your mind later you can leave the research. You do not have to give a reason for leaving. This will not affect the care you get from your clinical team.

Are there any risks or benefits?
We hope there are no risks to taking part in the research. We think it might be helpful for people to think about their recovery.

If you feel upset or tired when doing the questionnaires you can stop. You can finish them another time.

This is a pilot study. It is the first stage in the development of the SAFER questionnaire. This means there may be more research. You might be invited to take part again. Taking part in this project does not mean you need to take part in any other projects.

Will I receive any payment?
No, participants will not be paid for taking part in the research.

Will my taking part be kept confidential?
Yes. The information you provide will be treated confidentially. This means it is kept private. If you decide to take part some of the information you give might be seen by people who supervise the project. Everyone involved in the research must keep participant information private.

The information you give will be anonymous. This means your name will not be attached to any questionnaires. We will put the scores from the questionnaires onto a database. This will be saved securely on the University of Glasgow network. Your name will not be kept on this database. We will not put your name or any information about you in any reports we write.

If we are worried about your safety, or the safety of other people, we need to tell others involved in your care (your key worker or psychiatrist). We will always tell you first and explain why.

Will anyone else know I am taking part?
We will ask for your consent to tell your GP that you are taking part in the study (*remove for State Hospital patients*).

Staff in NHS Greater Glasgow & Clyde who sponsor the study may look at the information we collect. This is to make sure that the study is being carried out properly. They will not see your personal information.

What happens with the results of the research?
When we finish the study we will write a report. This will include the results of the study and ideas for future research. We will write about the results of the research anonymously, so your name and personal details will not be included in the report.

Will I find out about the results of the research?

Yes, you can have a summary of the results of the research.

What happens next?
Please take some time to think about whether or not you want to take part. I will contact the staff on your ward in a week to see if you are interested in taking part. If you are interested I will arrange to meet you. I will ask you to sign a consent form. I will also support you to complete the five questionnaires. I will arrange to meet with you two weeks later to complete the SAFER questionnaire for the second time.

Can I speak to someone who is not involved in the study?
Yes you can speak to Dr Hamish Mcleod. He can answer questions or give advice about taking part in this study. His telephone number is 0141 211 3922 (number to be removed for State Hospital patients).

What will happen if there is a problem or if I want to make a complaint?
If you are concerned about the study, the researchers or if you want to complain you can contact Professor Andrew Gumley. This is his address: Mental Health and Wellbeing, Gartnavel Royal Hospital, 1st Floor, Admin Building, University of Glasgow, Glasgow G12 0XH. You can also contact the Research & Development Department, NHS Greater Glasgow & Clyde. You can also complain through normal NHS complaint procedures. You can ask your key worker to help you with this.

Thank you

Emma Quill
Trainee Clinical Psychologist

Professor Andrew Gumley
Chief Investigator

Appendix 2.11: Participant Consent Form

Title of project: Developing a scale for assessing the forensic experience of recovery: the SAFER questionnaire

Name of researcher: Emma Quill, Trainee Clinical Psychologist

Please initial each box if you agree with the statement.

I have read and understood the information sheet provided dated 20.10.14 Version 2.2. ☐

I have had time to think about the information, ask questions about the study and have had these questions answered. ☐

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving a reason, and without my medical care or legal rights being affected. ☐

I understand that I will be asked to meet with the researcher on at least two occasions, once to complete five questionnaires and again after two weeks to complete the SAFER questionnaire for a second time. ☐

I consent to the researcher speaking with professionals involved in my care and treatment, for example, my key worker or Responsible Medical Officer. ☐

I consent to my Responsible Medical Officer (RMO) completing a questionnaire about my recovery. ☐

I understand that the information I provide and relevant information in my risk assessment report may be seen by authorised professionals involved in the research, for example, authorised persons from the study sponsor and/or the regulatory authorities may audit the project. ☐

I agree for my GP to be informed of my participation in the research. ☐

I understand that the information I provide is confidential, however, if there is any risk to me or others this information will be shared with my clinical team. ☐

I agree to participate in the study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 2.12: Letter of Participation

Mental Health and Wellbeing
University of Glasgow
Admin Building
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

Dear Dr

Developing a Scale for Assessing the Forensic Experience of Recovery: The SAFER questionnaire

Your patient, Mr/Mrs X, has consented to taking part in the project above. Participation involves completing five questionnaires – the SAFER questionnaire, the Individual Recovery Outcome Counter, the Recovery Assessment Scale, the Questionnaire about the Process of Recovery and the Psychosis Attachment Measure. I will meet / have met with Mr X to complete these questionnaires. Mr/Mrs X can withdraw from the study at any point if (s)he wishes.

As part of the research you, as responsible medical officer you will be asked to complete a short questionnaire, the Dundrum-4 Recovery Measure. This is to assess the relationship between participants and clinicians perception of recovery. The Dundrum-4 is a clinician rated tool and is part of a structured professional judgement instrument for assessing the need for therapeutic security. The Dundrum 4 contains six items – stability, insight, therapeutic rapport, leave, dynamic risk items and victim sensitivity. Each item is rated on a 5 point scale. **Please complete the enclosed questionnaire and return in the envelope provided.**

Who is conducting the research?

The research is being organised by the University of Glasgow, in collaboration with NHS Greater Glasgow & Clyde. I am a third year trainee on the Doctorate of Clinical Psychology programme at the University of Glasgow. The research is being supervised by Professor Andrew Gumley, University of Glasgow, who is also the Chief Investigator on this project. The field supervisors for the project are Dr Heather Laithwaite, Consultant Clinical Psychologist at Rowanbank Clinic, and Dr Emma Drysdale, Consultant Clinical Psychologist at the Douglas Inch Centre. Dr Natasha Purcell, Principal Clinical Psychologist at The State Hospital, is also involved in the project.

What is the research about?

This is a pilot study and is the first stage in the development of a self report measure of recovery suitable for use within forensic mental health settings. A recovery measure, conceptually based on the CHIME model of recovery and the Good Lives Model of offender rehabilitation, has been developed under supervision. This measure is called the Scale for Assessing the Forensic Experience of Recovery: SAFER.

The aims of this pilot project are to establish if forensic inpatients can be recruited to engage in research to validate the SAFER questionnaire and to explore aspects of the psychometric properties of the measure. We aim to explore the concurrent validity, test-retest reliability and internal consistency of the measure.

The questionnaire and research proposal has been shared with the Research and Audit Committee from NHSGG&C Directorate of Forensic Mental Health and Learning Disability and with the Research and Development Department at the State Hospital. The study has also been approved by the NHS Research Ethics Service and by the Research and Development departments at NHS GG&C and the State Hospital.

Should you have any concerns about Mr/Mrs X participation in this project or if you wish to discuss the research in further detail please do not hesitate to contact me.

Yours Sincerely,

Emma Quill
Trainee Clinical Psychologist

Professor Andrew Gumley
Chief Investigator

Dr Heather Laithwaite
Consultant Clinical Psychologist
Supervisor NHS GG&C

Dr Natasha Purcell
Principal Clinical Psychologist
Supervisor The State Hospital

c.c. GP

Appendix 2.13: Protocol

Title of project: Developing a Scale for Assessing the Forensic Experience of Recovery: the SAFER questionnaire

Abstract

The concept of recovery is important within current research and clinical practice. The CHIME model conceptualises recovery as connectedness, hope, identity, meaning in life and empowerment. The principles of recovery are equally applicable within forensic mental health. The Good Lives Model (GLM) is a strength based approach to offender rehabilitation consistent with a philosophy of recovery. This project is a feasibility study as part of the first phase of development of a self report measure of recovery suitable for use in a forensic mental health setting. A provisional measure has been created, the SAFER questionnaire, which is conceptually based on CHIME and the GLM. This project is a psychometric study and will use quantitative methods of analyse to explore the internal consistency, test-retest reliability, concurrent and discriminate validity of the measure. The association between recovery and attachment style will also be explored and comparison of participants' and clinicians' perception of recovery will be conducted. Participants will be recruited from low, medium and high secure inpatient services. The researcher will support participants to complete the SAFER questionnaire, the Individual Recovery Outcome Counter, Recovery Assessment Scale, Questionnaire on the Process of Recovery and Psychosis Attachment Measure. Responsible Medical Officers will be asked to complete a recovery measure and risk ratings will be obtained from HCR-20 reports. Item analysis will be conducted and items with inadequate variance removed. Internal consistency will be analysed using Cronbach's alpha. Test-retest reliability and concurrent validity will be evaluated using Pearson Correlation Coefficient. Receiver operating characteristic curve analysis will be conducted to explore discriminant validity. If preliminary data obtained through this feasibility study indicate that the measure is valid and reliable, a larger scale research project can be conducted to further develop the measure. Further development of the questionnaire could lead to it being validated for use locally and nationally within forensic mental health services.

Background Information

Recovery is an individual experience which involves learning to understand triggers, taking responsibility, having choice and striving for a meaningful life with hope and optimism being vital components (Scottish Recovery Network). Recovery involves not just overcoming mental illness but the associated consequences i.e. stigma, discrimination, reduced opportunities (Anthony, 1993). A potential factor influencing recovery is attachment style. Evidence suggests that insecure attachment is associated with poor engagement, interpersonal difficulties and poor quality of life (Gumley et al., 2014).

Within current policy and practice there is a move away from the medical model of focusing on pathology and measuring recovery through symptom reduction. A recovery approach focuses on individual strengths rather than illness (Wallcraft et al., 2007). A recovery approach began to emerge in the United States and New Zealand in the 1990's. Much of this work influenced research, policy and practice in the UK. In Scotland the concept of recovery began to take prominence in 2003 with the National Programme for Improving Mental Health and Wellbeing (Scottish Executive, 2003). As part of the commitment to a recovery approach the Scottish Recovery Network was launched in 2004 to promote awareness and contribute to research, policy and practice.

Leamy et al. (2011) conducted a systematic review with the aim of developing a conceptual framework for recovery and concluded that relevant processes are connectedness, hope and optimism, identity, meaning in life and empowerment (CHIME). The principles of recovery are equally applicable in forensic mental health (The Forensic Matrix, 2011) and research has discovered similar themes of recovery with forensic patients. A qualitative study exploring patients' perception of recovery within a high security hospital found that developing trust, relationships and having valued outcomes were important tasks of recovery (Laithwaite & Gumley, 2007). Turton et al. (2011) carried out qualitative research within specialist mental health services, one of which was forensic and found that hope, engagement, autonomy, insight, symptom management, choice and control and sense of self-worth were important recovery tasks.

Adopting a recovery approach within forensic settings can bring challenges. Forensic service users tend to be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 or Criminal Procedures (Scotland) Act 1995 and obliged to engage in

treatment. It can be difficult to manage autonomy, independence and promote choice within a forensic setting (Turton et al., 2011) and there is a balance between respecting the rights of the service user and the public (The Matrix, 2011). Service users have additional tasks to manage within their recovery e.g. learning to understand their offending behaviour and managing the restrictions imposed upon them (Simpson & Penney, 2011). Forensic service users are also likely to face stigma and discrimination due to their offences (Turton et al., 2011).

Despite these challenges recovery is possible and one psychological approach used within forensic settings, consistent with the philosophy of recovery is the Good Lives Model (GLM). This is a strength based approach to offender rehabilitation and suggests that everyone aims to construct a sense of purpose in their lives, which is achieved through the pursuit of 'primary goods' i.e. knowledge, excellence in play and work, autonomy, inner peace, relatedness, spirituality, happiness and creativity (Ward & Brown, 2004). Offenders have the same basic human needs as everyone else and offending behaviour occurs when someone lacks the capacity to achieve or has inappropriate means of securing primary goods (Whitehead et al., 2007). The GLM includes psychological, social, cultural, environmental, and biological factors in treatment planning and takes individuals' preferences and values into account. Treatment is based on personally salient goals and supporting individuals to develop skills necessary to meet their needs in a more socially desirable manner, in order to reduce recidivism (Ward & Brown, 2004).

Due to the multi-faceted definitions within the literature it can be difficult to accurately measure recovery, however, a number of self–report questionnaires have been validated. The Individual Recovery Outcomes Counter (I.ROC) was developed by Penumbra with service users and psychometrically assessed by researchers at University of Abertay Dundee. The I.ROC is based on Penumbra's HOPE model of recovery (home, opportunity, people and empowerment). The Recovery Assessment Scale (RAS) was developed collaboratively with service users in the US. It correlates

with quality of life, self esteem and empowerment (Corrigan et al., 1999) and contains five factors reflective of recovery - personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and not being dominated by symptoms (Corrigan et al., 2004). The Questionnaire of the Process of Recovery (QPR) is a self

report measure developed to assess recovery from psychosis. It contains interpersonal and intrapersonal components and was developed through analysis of interviews with service users in England (Neil et al., 2009).

Review of the literature regarding measurement of recovery in forensic mental health identified the Dundrum-4 recovery measure as a valid and reliable tool. It was developed in Ireland's only secure forensic hospital and is one component of a five part structured professional judgement instrument for assessing the need for therapeutic security (Davoren et al., 2013). It conceptualises recovery as finding hope, taking responsibility, establishing a positive identity and finding meaning in life. It measures recovery from the perspective of the clinician and aspects of the measure reflect a medical model e.g. assessing the presence or absence of symptoms. A self-rated instrument has been developed but not yet validated and is likely to contain the same items as the clinician rated measure (Davoren et al., 2013).

Aims

1) To develop a self-report measure of recovery conceptually based on CHIME and the GLM suitable for use within a forensic mental health.
2) To assess the psychometric properties of the measure developed e.g. internal consistency, test-retest reliability and concurrent and discriminant validity.

Research Questions

1) What is the internal consistency of the measure?
2) What is the test re-test reliability of the measure?
3) What is the concurrent validity the measure?
4) What is the discriminant validity of the measure?
5) Do participants' perceptions of recovery correlate with clinicians' perceptions of recovery?
6) Is there an association between participants' attachment style and recovery?

Hypothesis

6) It is predicted that the measure will show good internal consistency.

7) It is predicted that the measure will have good test-retest reliability as demonstrated by a correlation above 0.7 between participants' responses at two time points, two weeks apart.

8) It is predicted that there will be a moderate positive correlation, e.g. greater than 0.4, between the measure and the I.ROC, the RAS and the QPR.

9) It is predicted that the measure will be able to effectively discriminate between high and medium/low risk participants and there will be a negative correlation between participants' level of risk, as measured by the HCR-20, and recovery.

10) It is predicted that participants' perception of recovery will show a moderate correlation of 0.4 with clinicians' perception of recovery, as measured by the Dundrum 4 recovery tool for clinicians.

11) It is predicted that there will be a moderate correlation of 0.4 between higher scores on anxious and avoidant attachment scales, as measured by the Psychosis Attachment Measure (PAM), and recovery scores on the measure developed.

Participants

Inclusion criteria: Male and female forensic mental health inpatients from medium/low secure settings. No minimum length of stay in an inpatient facility is required for inclusion purposes. Patients are required to speak English.

Exclusion criteria: Based on the advice of responsible medical officer's (RMO) patients who do not have capacity to consent will not be invited to participate.

Recruitment Procedures

Responsible Medical Officers (RMO) and senior charge nurses will be contacted to request permission to recruit. The researcher will spend time on each ward, meeting with

patients and inviting them to participle. Patients will be provided with an information sheet describing the study. They will be given at least 24 hours after this initial meeting to decide if they wish to participate and before informed consent is sought. The researcher will return to the wards to enquire about interest in participation, ask any questions patients may have and obtain consent if they wish to participate. RMOs, key workers and GPs will be informed of patient participation.

Measures

Concurrent validity will be evaluated using the I.ROC, the RAS and the QPR. The I.ROC is a 12 item self report measure rated on a 6 point scale. Monger et al. (2013) found it to have high internal consistency (0.86), concurrent validity with the RAS and the Behaviour and Symptom Identification Scale while factor analysis revealed no redundant factors. It is chosen because it was developed with service users in Scotland and conceptualises recovery is a way which fits with the current research.

The RAS is a 41-item self report measure rated on a 5 point scale. It was developed with service users, has good test-retest reliability (r = 0.88) and internal consistency (Cronbach's alpha = 0.93) and positively correlates with the Self-Esteem Scale, Empowerment Scale, Quality of Life Interview and Social Support Questionnaire (Corrigan et al., 1999).

The QPR is a 22 item self-report questionnaire, developed with service users, rated on a 5 point scale. Neil et al. (2009) found the measure to have good internal consistency (Cronbach's alpha; subscale 1 α=0.94; subscale 2 α=0.77), test re test reliability (intrapersonal subscale r=0.874, p=0.001 and interpersonal subscale r=0.769, p=0.001). It also had concurrent validity with the General Health Questionnaire, the Making Decisions and Empowerment Scale and the Schizophrenia Quality of Life Scale.

The HCR-20 will be used to analyse discriminant validity. The HCR-20 is a well validated, widely used tool which is based on a Structured Professional Judgement model of violence risk assessment and management. It contains 10 historical items, 5 clinical

variables and 5 future risk management items, each rated on a 3 point scale; 0=absent, 1=possibly/partially present and 2=definitely present.

To explore the relationship between participants and clinicians' perception of recovery the Dundrum-4 clinician rated recovery measure will be compared to participants' self-reports. The Dundrum-4 is a clinician rated tool containing six items, rated on a 5 point scale. O'Dwyer et al. (2011) found that it had significant inter-rate reliability and internal consistency (Cronbach's alpha 0.887), that it correlated significantly with the Positive and Negative Symptom Scale (r = 0.596), the Global Assessment of Function (-0.673) and the HCR-20 dynamic items (r = 0.70). It also discriminated between patients permitted and not permitted unaccompanied leave from a secure hospital (ANOVA F = 76.8, p <0.001).

To explore the association between participants' attachment style and recovery the PAM will be used. The PAM is a 16 item self report questionnaire which uses a four point Likert scale to assess anxious and avoidant attachment styles. A range of studies have demonstrated internal consistency - Cronbach's alpha coefficients ranging from 0.70 to 0.86 for the anxiety dimension and from 0.60 to 0.91 for the avoidance dimension (Gumley et al., 2014).

Design

This will be a psychometric study which will employ quantitative methods of analysis.

Research Procedures

A questionnaire has been developed under supervision of a member of the academic team at University of Glasgow Doctorate in Clinical Psychology Programme and a consultant clinical psychologist working within DFMHLD. To create a conceptual framework the processes of recovery outlined in the CHIME model and the description of primary goods from the GLM were explored to identify overlapping concepts.

The questionnaire developed contains 24 items each with two components. The first part relates to a value and requires participants to indicate if the value is important to them with a yes or no answer. If the value is important, then participants are asked to indicate the

extent to which they feel they are living in a way which is consistent with this value. The questionnaire was called the Scale for Assessing the Forensic Experience of Recovery (SAFER). The questionnaire and research proposal will be shared with a steering group for consultation - a multi-disciplinary Research and Audit Committee from Rowanbank and the Research and Development Department the State Hospital.

The finalised questionnaire, plus the I.ROC, RAS, QPR and PAM will be distributed to consenting participants. It is estimated that the questionnaires will take between 60 minutes and 90 minutes to complete. This is a considerable amount of patient time. This is a vulnerable population, often with severe, enduring and a range of co-morbid mental health difficulties, (The Matrix, 2011). It is likely that some participants may struggle to retain concentration for length of time required. It is also possible that participants may have other commitments and as such be unable to offer 60-90 minutes of their time in one setting. Taking these factors into account, participants can take a break at any time but as a matter of course we will invite participants to take a break after 60 minutes. In addition to this, questionnaires can be completed over two sessions if necessary. Furthermore, all sessions will be arranged to accommodate patients' commitments in order to ensure least disruption possible to their regular routine. Finally the researcher will read the questionnaires aloud to all participants and ask for a verbal response, so as not to disadvantage any patients with literacy difficulties.

The researcher will return to meet participants after two weeks so that they can complete the SAFER questionnaire again to evaluate test-retest reliability. This procedure will take approximately 15-20 minutes.

In order to obtain qualitative information about participants' perception of the questionnaire they will be asked to answer three questions about the SAFER questionnaire: "What did you like about the questionnaire?", "What did you dislike about the questionnaire?", "Is there anything you would change?" They will only be asked these questions once and this will be after completing the questionnaire the first time. Participants' RMOs will be asked to complete the Dundrum-4 recovery measure. The researcher will also obtain ratings from participants' HCR-20 risk assessment reports.

Data Analysis

Item analysis will be conducted and items with inadequate variance removed (as indicated by 80% or more agreement). Internal consistency will be analysed using Cronbach's alpha and items which reduce the overall reliability of the questionnaire will be removed. To reflect the two components, a value scale and an associated experience scale will be separately analysed. Test-retest reliability and concurrent validity will be evaluated using Pearson Correlation Coefficient. Discriminant validity will be evaluated using receiver operating characteristic curve (ROC). Pearson Correlation Coefficient will be calculated to explore the relationship between participant and clinician perception of recovery and to explore the association between recovery and attachment style.

Justification of Sample Size

A sample of 27 is needed to find a large effect size (0.8) in order to determine test-retest reliability (table 1). Table two indicates that a sample of 34 is needed to obtain a large enough effect size (0.8) to determine concurrent validity between the SAFER and the I.ROC, RAS and QPR. A sample size of 34 would also be needed to effectively evaluate the relationship between attachment and recovery and to explore the relationship between participant and clinician perception of recover. In order to calculate discriminant validity of the SAFER measure using receiver operating characteristic curve, it is hypothesised that an area under the curve of 0.8 and a null hypothesis value of 0.5, assuming significance of 0.05 and power of 80 and assuming equal sample sizes, would require a sample size of 52. This is 20% of the approximate 255 patients across hospitals sampled. It is hoped that 26 participants will be recruited from high secure and 26 from low and medium secure.

Table 1 – Power calculation: Test Re-test Reliability

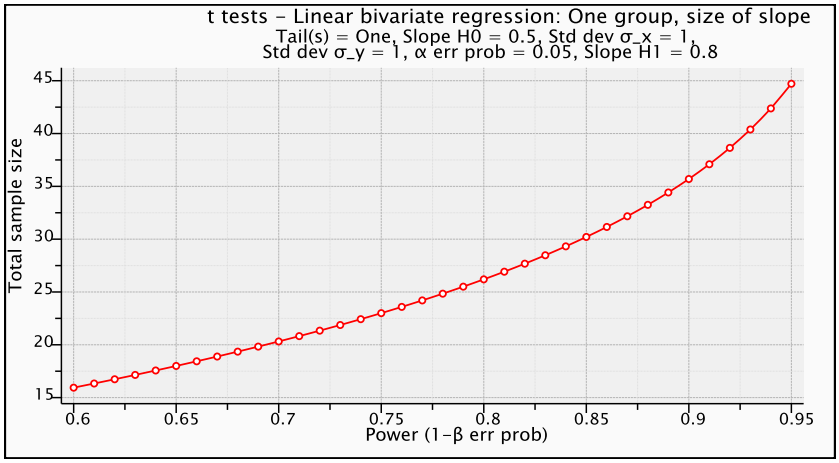
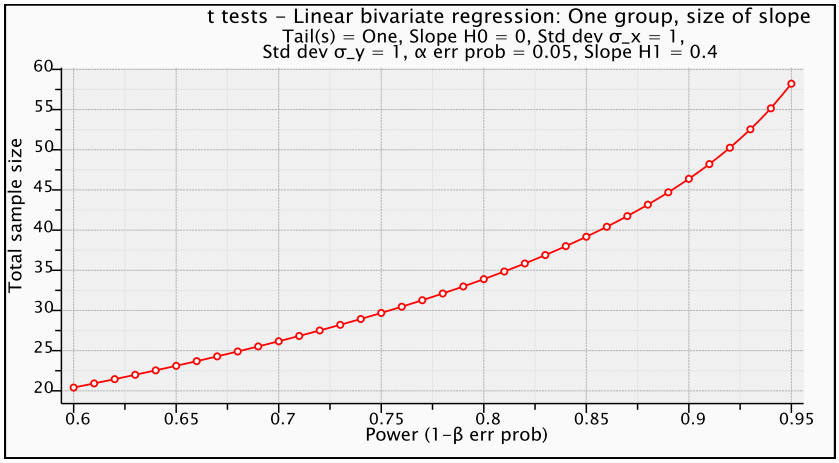


Table 2: Power Calculation: Concurrent validity



Settings and Equipment

Research will take place at Leverndale Hospital, Rowanbank Clinic and The State Hospital. A quiet meeting room with a table and chair will be needed for participants to complete the questionnaires. In order to respect confidentiality all paper and electronic data will be made anonymous and marked with a unique patient identifier. All paper copies of questionnaires will be stored in a locked filing cabinet at the University of Glasgow. A locked brief case will be used to transport questionnaires between the study site and the university. Electronic data will be stored anonymously, again using a unique patient identifier, on the University of Glasgow Network. Access to SPSS to analyse the data is freely available on university laptops.

Health and safety issues

Risk is minimised by safety procedures in operation within secure NHS hospitals. The researcher is trained in "Breakaway" techniques and has experience of working in a medium secure hospital. The researcher will carry a personal alarm which if activated results in an immediate response from staff trained in control and restraint techniques. Prior to meeting participants the researcher will read risk assessment reports and speak to the clinical team about specific risk issues. On the day of meeting participants the researcher will obtain an update and will cancel arranged meetings if any risk issues are raised. The researcher will ask each participant's clinical team about the specific safety procedures in operation for that patient, including whether that patient can be seen alone or requires a member of staff present. The researcher will follow the guidance provided by the clinical team relating to safety procedures in operation for each patient.

It is hoped that the planned procedures and questionnaires used should not result in distress to participants, however, in the event of a participant becoming distressed during the research the session will be ended and the researcher will ask the participant's clinical team to provide support. The researcher will inform the participant's RMO if any such event occurs. The researcher will arrange to meet the participant at a more suitable time to continue with the researcher if they wish to continue to be involved. All participants have the right to withdraw their participation at any time, with out being questioned.

Ethical considerations

Information will be treated as confidential unless risk of harm to self or others is raised, in which case the researcher will share this information with the RMO and senior charge nurse. Information will be presented anonymously to respect patient confidentiality. Each patient will be given a unique patient identifier which will be used on paper and electronic data. No personal identifiable information will be stored during the research. A system will be put in place so that the researcher is aware of data from various levels of security, for example, A1–A26 from high secure setting, B1–B26 from medium/low secure setting. Patients will be made aware that participation will not impact upon their routine care and they have a right to withdraw at any point. Supervision will be held regularly.

When conducting research with a vulnerable group the potential costs and benefits need to be carefully considered, keeping in mind the best interests of participants. A potential cost and as such ethical implication of the proposed project is that principal component analysis will be not conducted. The rationale for this decision is based on the fact that the SAFER questionnaire is in the very early phase of development. As such this is a feasibility project to assess the acceptability of the questionnaire to forensic service users and to gather preliminary data regarding the reliability and validity of the measure. If this initial stage in the development of the SAFER questionnaire is successful, research can progress to the next stage which would involve a larger scale study to allow for principal component analysis. It is proposed that preliminary data regarding reliability and validity is essential before justification can be made for such a large scale research project. It is also proposed that to conduct a large scale study in this early stage of the development of this questionnaire, without any such preliminary evidence of the utility of the tool, simply to allow for principal component analysis could potentially be unethical.

A potential drawback to this staged plan of development is that participants could potentially be asked to be involved in further research thus taking up more of their time. Service users will be informed via the participant information sheet that this project is the first phase of the development of the SAFER questionnaire. It is important to highlight that there is no expectation that participating in this project implies any agreement to participate in any future research regarding the development of the questionnaire. Service users will be informed of the potential costs and benefits of participating and they have a right to refuse to participate in this project. Equally, should this project lead to further

research in the development of the measure forensic patients will again be fully informed about the project if invited to participate and again would have the right to refuse to be involved. As such participation in this project, or any further research, would be an informed decision on the part of forensic service users.

Although there is no direct therapeutic benefit to participants in this project, there is a possibility that participants may benefit from having an opportunity to reflect on their recovery and knowing that their opinions regarding a suitable measure for recovery are highly valued. If this project provides preliminary evidence for the reliability and validity of the tool and leads to further development of the measure it could potentially benefit forensic mental health patients in the longer term.

Dissemination of Findings

The strategy for knowledge exchange encompasses dissemination to three main groups. Firstly a summary of the findings will be produced and disseminated to service users who participated in the project. Secondly the findings of the research will be disseminated to the Forensic Network to raise the profile of the recovery from mental illness and the importance measuring recovery. Finally it is hoped that the findings will be published in a peer reviewed journal. A report of the findings will also be produced as part of Doctorate of Clinical Psychology Thesis. All reports and presentations will be made anonymous to respect patient confidentiality.

Timetable

August/September 2014	Apply for ethical approval
October 2014	Recruitment
March 2015	Analysis
April 2015	Write up
May 2015	1st draft to supervisor
June 2015	2nd draft to supervisor

Practical Applications

If preliminary data obtained through this feasibility study indicate that the measure is valid and reliable, a larger scale research project can be conducted to further develop the measure. Further development of the questionnaire could lead to it being validated for use locally and nationally within forensic mental health services.

Changes to protocol following submission to ethics

- Information sheets offered to patients by staff rather than the researcher.
- The aim to explore discriminant validity was retracted. This was due to ethical issues raised regarding researchers accessing participants' risk assessments, the fact that HCR-20 risk assessments are not scored in clinical practice and lack of valid and reliable cut off points based on population norms which would have made conversion of HCR-20 scores into binary data unreliable.
- Sample size was recalculated in consultation with a statistician at the University of Glasgow as there were errors in original power calculations.
- The protocol was altered to clarify this was a pilot study and sample size was based on estimation of concurrent validity of the SAFER.

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Appendix 2.14: Research Ethics Committee Approval Letter

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

West of Scotland REC 5
Ground Floor - Tennent Building
Western Infirmary
38 Church Street
Glasgow
G11 6NT

Date 31 October 2014

Direct line 0141 211 2102
E-mail WoSREC5@ggc.scot.nhs.uk

Professor Andrew Gumley
Institute of Mental Health and Wellbeing
Administration Building
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Dear Professor Gumley

Study title: **Developing a scale for assessing the forensic experience of recovery: the SAFER questionnaire**
REC reference: **14/WS/1099**
IRAS project ID: **157323**

I refer to Emma Quill's letter of 24 October 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

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 opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Sharon Macgregor, WoSREC5@ggc.scot.nhs.uk.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

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

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

Management permission ("R&D approval") should be sought from all NHS organisations

Appendix 2.15: Calculations on SAFER without item 23 (I value other people being open about risk) and item 24 (I value talking to other people about risk)

Normality: SAFER scores (minus risk items) were normally distributed at time point one, *D* (46) = .09 (p>.05) and time point two *D* (46) = .10 (p>.05).

Concurrent validity: Correlations between the SAFER (minus risk items) and I.ROC, RAS and QPR were evaluated using Pearson correlation coefficient. There was a moderate positive correlation between the SAFER and the I.ROC, *r*=.48, N=46, (p<.05); the RAS, *r*=.35, N=46, (p<.05) and the QPR Intrapersonal subscale, *r*=.60, N=46, (p<.05). There was no significant association with the QPR Interpersonal subscale, *r*=.26, N=46, (p>.05).

Test- Retest Reliability: Correlations between the SAFER scores (minus risk items) collected at two time points were evaluated using Pearson correlation coefficient. There was a strong positive correlation between scores collected two weeks apart, *r*=.79, N=46, (p<.05), indicating good test retest reliability.

Internal consistency: Cronbach alpha was used to evaluate internal consistency and results indicated the SAFER (minus risk items) has good internal consistency (α=.92, 95% CI = .88, .95).

Recovery and Attachment: The relationship between recovery and attachment was evaluated using Pearson correlation coefficient. There was a moderate correlation between the SAFER (minus risk items) and the PAM Avoidance Subscale, *r*=-.48, N=46, (p<.05). There was no significant association between the SAFER (minus risk items) and PAM Anxiety subscale *r*= -.00, N=46, (p>0.5).

Appendix 2.16: Analysis of difference between participants with and without corresponding RMO recovery measure

An independent-samples t-test was conducted to compare age, SAFER, I.ROC, RAS, QPR and PAM scores amongst participants for whom the Dundrum 4 was and was not completed by RMOs. There were no significant differences found in scores on the SAFER for those for whom the Dundrum 4 was returned (*M* =2.12, *SD* =0.56) and for whom the Dundrum was not returned (*M* = 1.96, *SD* = 0.55; *t* (44) = -.90, *p* > .05).

There were no significant differences found in scores on the IROC for those for whom the Dundrum 4 was returned (*M* = 52.95, *SD* =9.20) and for whom the Dundrum was not returned (*M* = 49.29, *SD* = 10.56; *t* (44) = -.95, *p* > .05).

There were no significant differences found in scores on the RAS for those for whom the Dundrum 4 was returned (*M* = 167, *SD* = 15.60) and for whom the Dundrum was not returned (*M* = 165, *SD* = 15.61; *t* (44) = -.22, *p* > .05).

There were no significant differences found in scores on the QPR intra or interpersonal subscales for those for whom the Dundrum 4 was returned (Intrapersonal subscale: *M* = 52.12, *SD* =6.2; Interpersonal subscale: *M* = 14.59, *SD* = 2.97) and for whom the Dundrum was not returned (Intrapersonal subscale: *M* = 47.71, *SD* =8.07 ; *t* (44) = -1.66, *p* > .05; Interpersonal subscale: *M* = 13.71, *SD* = 3.25; *t* (44) = -0.70, *p* > .05).

There were no significant differences found in scores on the PAM avoidant subscales for those for whom the Dundrum 4 was returned (avoidant subscale: *M* =1.25, *SD* =0.47) and for whom the Dundrum was not returned (avoidant subscale: *M* = 1.53, *SD* = .53; *t* (44) = 1.44, *p* > .05).

There was a difference in scores on the PAM anxiety subscale for those for whom the Dundrum 4 was returned (anxiety subscale: *M* = 0.77, *SD* = 0.55) and for whom the Dundrum was not returned (anxiety subscale: *M* = 1.32, *SD* = 0.81; *t* (44) = 2.30, *p* < .05).

There were also no significant differences in relation to participants age for those for whom the Dundrum was returned (*M* = 43, *SD* = 9.9) and for whom the Dundrum was not returned (*M* = 35, *SD* = 13.5; *t* (44) = -1.8, *p* > .05).

Appendix 2.17: SAFER updated following feedback from participants

SAFER: Scale for Assessing the Forensic Experience of Recovery
This questionnaire has 24 statements. Each statement has two parts. The first part asks if a value, activity or experience in your life is important to you. You can answer yes or no. A value is something that you feel is important in your life. Your values can motivate you to behave in a certain way or can influence how you live your life.

If you answer yes, that the value is important to you, there is a second part that asks you to rate how much you feel you are living in a way that is in keeping with that value. There is space beneath each question for you to explain why you have chosen each answer. It is best to complete this with a member of staff so you can talk about your values and your recovery.

Please try to answer each statement. There are no right or wrong answers.

1) I value close relationships with family and friends	**No**	**Yes**		
If yes: I feel I have close relationships with family and friends	**Not at all**	**A little**	**Moderately**	**Very much**
2) I value being able to repair difficult relationships	**No**	**Yes**		
If yes: I feel that I can repair difficult relationships.	**Not at all**	**A little**	**Moderately**	**Very much**

3) I value building new relationships	**No**	**Yes**		
If yes: I feel that I can build new relationships	**Not at all**	**A little**	**Moderately**	**Very much**
4) I value support from fellow patients	**No**	**Yes**		
If yes: I feel supported by fellow patients	**Not at all**	**A little**	**Moderately**	**Very much**
5) I value being part of a community	**No**	**Yes**		
If yes: I feel part of a community	**Not at all**	**A little**	**Moderately**	**Very much**
6) I value having hope for the future	**No**	**Yes**		

If yes: I feel hopeful for the future	**Not at all**	**A little**	**Moderately**	**Very much**

7) I value when others are optimistic about my future	**No**	**Yes**

If yes: I feel that others are optimistic for my future	**Not at all**	**A little**	**Moderately**	**Very much**

8) I value having things to look forward to	**No**	**Yes**

If yes: I feel that I have things to look forward to	**Not at all**	**A little**	**Moderately**	**Very much**

9) I value having motivation to make changes in my life	**No**	**Yes**		
If yes: I feel motivated to make changes in my life	**Not at all**	**A little**	**Moderately**	**Very much**
10) I value being the person I am	**No**	**Yes**		
If yes: I feel happy with the person I am	**Not at all**	**A little**	**Moderately**	**Very much**
11) I value having confidence	**No**	**Yes**		
If yes: I feel confident	**Not at all**	**A little**	**Moderately**	**Very much**

12) I value others accepting my mental health difficulties	**No**	**Yes**		
If yes: I feel that others accept my mental health difficulties	**Not at all**	**A little**	**Moderately**	**Very much**
13) I value having purpose to my life	**No**	**Yes**		
If yes: I feel that I have purpose to my life	**Not at all**	**A little**	**Moderately**	**Very much**
14) I value having a healthy lifestyle	**No**	**Yes**		
If yes: I feel I have a healthy lifestyle	**Not at all**	**A little**	**Moderately**	**Very much**

15) I value having happiness in life	**No**	**Yes**		
If yes: I feel happy	**Not at all**	**A little**	**Moderately**	**Very much**
16) I value having a role in the community in which I live	**No**	**Yes**		
If yes: I feel that I have a role in the community in which I live	**Not at all**	**A little**	**Moderately**	**Very much**
17) I value having an understanding of my mental health difficulties	**No**	**Yes**		
If yes: I feel that I understand my mental health difficulties	**Not at all**	**A little**	**Moderately**	**Very much**

18) I value having control over my life	**No**	**Yes**		
If yes: I feel I have control over my life	**Not at all**	**A little**	**Moderately**	**Very much**
19) I value having choices about my care and treatment	**No**	**Yes**		
If yes: I feel that I have choices about my care and treatment	**Not at all**	**A little**	**Moderately**	**Very much**
20) I value having responsibility	**No**	**Yes**		
If yes: I feel that I have enough responsibility	**Not at all**	**A little**	**Moderately**	**Very much**

21) I value when people focus on the things I do well	**No**	**Yes**		
If yes: I feel that people focus on the things I do well	**Not at all**	**A little**	**Moderately**	**Very much**
22) I value being able to express myself	**No**	**Yes**		
If yes: I feel that I can express myself	**Not at all**	**A little**	**Moderately**	**Very much**
23) I value staff being honest with me about my risk of re-offending	**No**	**Yes**		
If yes: I feel that staff are honest with me about my risk of re-offending	**Not at all**	**A little**	**Moderately**	**Very much**

24) I value talking to staff about my risk of re-offending	**No**	**Yes**

If yes: I feel that I can talk to staff about risk	**Not at all**	**A little**	**Moderately**	**Very much**

Thank you for completing this questionnaire.