

STAFF PERCEPTION OF PERSONAL RESPONSIBILITY IN FORENSIC MENTAL
HEALTH SERVICES: A THEMATIC ANALYSIS

By

SOPHIA BARFORD

A thesis submitted to the University of Birmingham for the degree of DOCTOR OF
FORENSIC CLINICAL PSYCHOLOGY

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Thesis Overview

This thesis is submitted as part of the Doctorate in Forensic Clinical Psychology at the School of Psychology, University of Birmingham. It comprises two volumes.

Volume I: Research Component

Volume I consists of a systematic literature review and an empirical paper. The systematic literature review presents the identification and critical evaluation of quantitative measures of personal recovery in forensic settings. The empirical paper presents a qualitative study exploring staff perspectives of personal responsibility in forensic mental health. Press releases for the literature review and empirical paper are also presented. Each provides an accessible overview of each piece of research.

Volume II: Clinical Component

Volume II consists of five Forensic Clinical Practice Reports (FCPR). Pseudonyms are used throughout to ensure anonymity. FCPR 1 presents a cognitive behavioural and a systemic formulation of a 29-year-old male with a diagnosis of Paranoid schizophrenia and Asperger's syndrome. FCPR 2 is a service evaluation exploring staff and patient views of positive behaviour support plans in an ASD inpatient service. FCPR 3 reports a single case experimental design used to evaluate a differential reinforcement of alternative behaviour intervention for a self-injurious behaviour for a 69-year-old male with dissocial personality disorder and emotionally unstable personality disorder diagnoses. FCPR 4 presents a case study of a 12-year-old girl experiencing anxiety. FCPR 5 presents an abstract of an oral presentation of a service evaluation exploring staff and prisoner views of the assessment, care in custody and teamwork (ACCT) process in a category B prison.

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Volume I: Research Component

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VOLUME I

SYSTEMATIC LITERATURE REVIEW

THE USE OF QUANTITATIVE MEASURES OF PERSONAL RECOVERY IN
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Abstract

Rationale

The recovery paradigm is leading in mental health research, policy, and practice. However, there is a discrepancy between clinical and forensic fields. Despite the development of up to 35 published measures of personal recovery (Moreno & Uriarte, 2019), there had been no review of quantitative measures in forensic settings. Therefore, the systematic review aimed to identify and critically evaluate the use of quantitative measures of personal recovery in forensic settings.

Methods

Three databases were used to conduct a systematic search of the literature: PsycInfo, Web of Science, and Embase. The search yielded 7591 results, with 11 studies meeting the inclusion criteria. The 11 articles were systematically reviewed, and a quality appraisal of each study was conducted.

Results

Four quantitative measures of personal recovery were identified: the Maryland Assessment of Recovery in Serious Mental Illness (MARS), Recovery Assessment Scale (RAS), Mental Health Recovery Measure (MHRM), and Questionnaire about Process of Recovery (QPR). The papers inconsistently reported psychometric properties, and five studies were rated of moderate risk of bias. Several designs and analyses were noted with the studies evidencing interventions to increase personal recovery. However, if used as secondary outcomes, no significant changes were observed. Significant relationships with other constructs showed parallels with clinical settings.

Conclusion

The review suggests the appropriate use of personal recovery measures in forensic settings, specifically the RAS-41 and MHRM, due to alignment with theory and psychometric strength. However, how and why they are used needs consideration within the study design. The limited evidence base is acknowledged, with recommendations for further research made.

Introduction

Background

The recovery movement in mental health has gathered momentum over recent decades, shaping research, policy, and practice. The concept is not new, with links to clinical philosophies dating back to the 1800s and integration into professional literature from the early 1990s (Roberts & Wolfson, 2004). Nevertheless, it is hailed as a rediscovered concept due to the alignment of deinstitutionalisation, the increased value of service user experience, longitudinal studies of mental health, and acceptance of strength and social disability models (Ramon et al., 2007).

The definition of recovery has also shifted in this time, with a conceptual distinction between clinical recovery and personal recovery. Clinical recovery refers to a measurable change in symptoms of an illness and the absence of disease (Torgalsbøen, 2005). Personal recovery focuses on individually outlined progress. It is defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness" (Anthony, 1993, p. 527). This interpretation highlights the process of recovery with continued clinical symptoms, captured as 'recovery in' rather than 'recovery from' (Davidson & Roe, 2007). Despite the separation, the two concepts are not contraries and can unify an overall goal of recovery (Roberts & Wolfson, 2004).

Still, the concept of personal recovery has also faced criticism. Critiques note its capacity to be open to interpretation, the limited evidence base, perceived contradiction with traditional perspectives, and difficulties with implementation into services (Davidson et al., 2006; Jacobson & Greenley, 2001). Concerns also note the contradiction in defining personal recovery as a construct when it is understood to be a unique and individualised process.

Development within research has resulted in recovery frameworks outlining central components of the process. These include the RECOVER and HEART recovery framework (Lapsley et al., 2002), the Personal Recovery Framework (Slade, 2009), and the SAMHSA framework (Substance Abuse and Mental Health Services Administration, 2006, 2012). Most prominent is the development of the CHIME framework (Leamy et al., 2011). The CHIME framework is the most widely endorsed recovery framework, with evidenced validity across English-speaking cultures (Slade et al., 2012; van Weeghel et al., 2019).

The CHIME framework was developed in line with a systematic review and meta-synthesis, examining a total of 97 papers (Leamy et al., 2011). The framework comprises three interlinking categories: 13 characteristics of the recovery journey, five recovery processes, and recovery stage descriptions mapping onto a model of change. The five recovery processes underpinning the concept are 'connectedness', 'hope and optimism about the future', 'identity', 'meaning in life', and 'empowerment'. These form the acronym CHIME. See Table 1 for the components and the supporting characteristics from the literature. Leamy et al. (2011) also state that studies that focused on recovery for individuals from Black and ethnic minority backgrounds found 'culturally specific facilitating factors' and 'collectivist notions of recovery' to be additional themes. Leamy et al. (2011) concluded that the framework would be suitable to guide clinical intervention and evaluation strategies, including the creation of valid measures of personal recovery.

Table 1. Categories of the CHIME recovery model and the supporting characteristics found in the literature (Leamy et al., 2011).

Category	Supporting Characteristics
Connectedness	Peer support and support groups Relationships Support from others Being part of the community
Hope and optimism about the future	Belief in the possibility of recovery Motivation to change Hope-inspiring relationships Positive thinking and valuing success Having dreams and aspirations
Identity	Dimensions of identity Rebuilding/redefining the positive sense of identity Overcoming stigma
Meaning in life	Meaning of mental illness experiences Spirituality Quality of life Meaningful life and social roles Rebuilding life
Empowerment	Personal responsibility Control over life Focusing upon strengths

Measures of Personal Recovery

Despite the complexity, the recovery process is considered a measurable dimension of change, therefore, it can allow for the use of recovery outcomes (Slade, 2002). However, the literature reports routine clinical outcome measures administered by services fail to capture

critical aspects of recovery (Andresen et al., 2010), highlighting a disconnect with current clinical practice and an established need for measures.

Personal recovery measures have been present in the literature from the 1990s, with current reviews suggesting up to 35 published measures (Moreno & Uriarte, 2019). Despite the apparent quantity, quality concerns have been raised (Moreno & Uriarte, 2019; Shanks et al., 2013; Sklar et al., 2013). These reviews highlight the lack of consensus among the tools, evidenced by inconsistent dimensions of the construct and failure to meet standards for psychometric quality. Consequently, a challenge as to which measures are most appropriate to administer is present. The development of the CHIME framework, together with evaluations of psychometric properties, increased ease of administration, and service-user involvement in existing measures (Burgess et al., 2011; Sklar et al., 2013) have attempted to solve this challenge.

A comprehensive review of available measures was completed by Shanks et al. (2013), which evaluated psychometric proprieties and adherence to the CHIME framework. This is valuable given that the CHIME framework has been found to have good utility to guide instrument choice and evaluate measures (Vogel et al., 2020). A total of 12 measures of personal recovery were identified. Of these, none demonstrated all nine psychometric properties investigated. The Questionnaire about the Process of Recovery (QPR) (Neil et al., 2013) was best aligned with the CHIME framework. However, further reviews have been unable to replicate this. Instead, a recent review argued the Mental Health Recovery Measure (MHRM) best fits the CHIME framework (Vogel et al., 2020). Consequently, the literature provides a wealth of existing measures, yet no personal recovery measure can be unequivocally recommended.

Personal Recovery within a Forensic Mental Health Settings

Notable within the literature is the discrepancy between clinical and forensic mental health fields. The majority of research is conducted with clinical populations, creating limited evidence in the applicability of the model in forensic mental health services. Shortfalls may be due to the unique characteristics of forensic mental health service users, and thus, additional challenges in applying a recovery model (Simpson & Penney, 2011). These note issues of social exclusion, higher levels of hopelessness, difficulties with empowerment in the criminal justice system, and possible antisocial intentions and values (Dorkins & Adshead, 2011). Most frequently remarked is the dual task of forensic mental health services, moving towards recovery and reducing risk, with these considered as being in tension (Livingston et al., 2012). Due to the complex histories of many forensic mental health service users, including trauma and interpersonal difficulties, the recovery model could add tremendous value. Furthermore, UK forensic mental health services have aimed to increase their coherence with general mental health services (Mullen, 2000). Thus, the integration of a recovery paradigm is supported.

Current research within forensic mental health settings predominately uses qualitative approaches due to the idiographic nature of personal recovery and limited established frameworks (Shepherd et al., 2016). Some meta-syntheses have identified specific themes to forensic mental health settings. Those identified are 'safety and security as a base', 'hope and social networks in supporting the recovery process', and 'working on identity as a changing feature in the recovery process' (Shepherd et al., 2016); 'connectedness', 'sense of self', 'coming to terms with the past', 'freedom', 'hope and health', and 'intervention' (Clarke et al., 2016); and 'process', 'autonomy', 'relating to others', 'self-identity', 'hope', 'intervention and health', 'activities', 'security', and 'stigma' (McKenzie-Smith, 2019). The themes align with clinical settings, yet additional aspects are consistently present. This may reflect the challenges present in this population. Due to the unique aspect of risk, Pollak et al. (2018)

specifically investigated which aspects of personal recovery were important in reducing risk, identifying 'time', 'trust', 'hope', and 'toolbox' (of skills). The authors conclude that these themes fit into established personal recovery processes in general psychiatric populations. Thus, existing personal recovery literature may be suitable to dovetail into forensic psychology.

A recent theoretical model of service user experiences of recovery in forensic mental health settings consists of five core recovery processes; 'environment', 'connectedness', 'hope for the future', 'who am I', and 'empowerment' which occurs over three phases of 'feeling safe and secure', 'moving forward', and 'empowerment' (Lovell et al., 2020). The authors acknowledge shared traits with Maslow's Hierarchy of Needs (1943). However, it also appears to contain parallels with the CHIME framework. Future implications made by Lovell et al. recommended using a quantitative methodology to examine if a personal recovery measure maps onto the proposed model.

Rationale for Review

Advantages of incorporating recovery into forensic mental health settings are present at an individual through to systemic level, with impact on society and service users (Lovell et al., 2020). However, the presence of personal recovery in forensic mental health policy and literature is lagging. Current research has been able to identify critical components of recovery for forensic mental health populations, aligning with those in general mental health. A natural progression of the literature leads to consideration of quantitative methodology. To date, there has been no review of quantitative measures of personal recovery in forensic mental health settings. Reviewing these measures is imperative to understand current measures' ability to be generalised to forensic mental health populations and settings, especially given the similarities and discrepancies between fields.

Aim of the Review

This systematic review aims to identify and critically evaluate the use of quantitative measures of personal recovery in forensic mental health settings. Specifically, the review aims to answer the following questions:

- Which measures of personal recovery are used within forensic mental health settings?
- How are these measures used in forensic mental health settings?
- What have these measures found?
- Are currently used measures of personal recovery appropriate in forensic mental health settings?

Conclusions drawn from these questions will provide critical information to guide practice and future research to ensure an appropriate integration of recovery into forensic mental health services.

Methodology

Search Strategy

Three electronic databases were searched: PsycInfo, Web of Science, and Embase. All databases were searched in January 2020 using the terms outlined in Table 2, with a criterion of a published date of 2011 or later. The search terms were identified from the title, abstract, or keywords, and the citations of final papers were reviewed for any further studies that met the eligibility criteria. The search strategy process can be found in Figure 1.

Table 2. Search terms used to identify papers for the review.

Concept	Search Terms
Forensic	Forensic OR Offend* OR *Risk OR Criminal* OR Prison OR *Secure OR Justice
Recovery	Recover* OR Rehabilitat*
Mental Health	Ment* OR Psychia* OR Schizo*.

As illustrated in Figure 1, ten papers were excluded due to an inappropriate measure of personal recovery, four papers were excluded due to an inappropriate concept of recovery, and one paper excluded on the basis of an inappropriate population. These exclusions were made due to the eligibility criteria in Table 3. See Appendix A for details of papers excluded at the eligibility stage and the justifications for this.

A final sample of 11 papers were included in the review. Two papers (Livingston et al., 2012; Livingston et al., 2013) contain the same participant sample, using different study designs and analyses to contribute to two published papers. Due to the use of the same sample the two papers will be presented as one study, presented as Livingston et al. (2013). Thus, the review has a total of 10 papers. However, the different designs will be recognised in the quality appraisal, and the different analyses and results will be documented in the results of this systematic review.

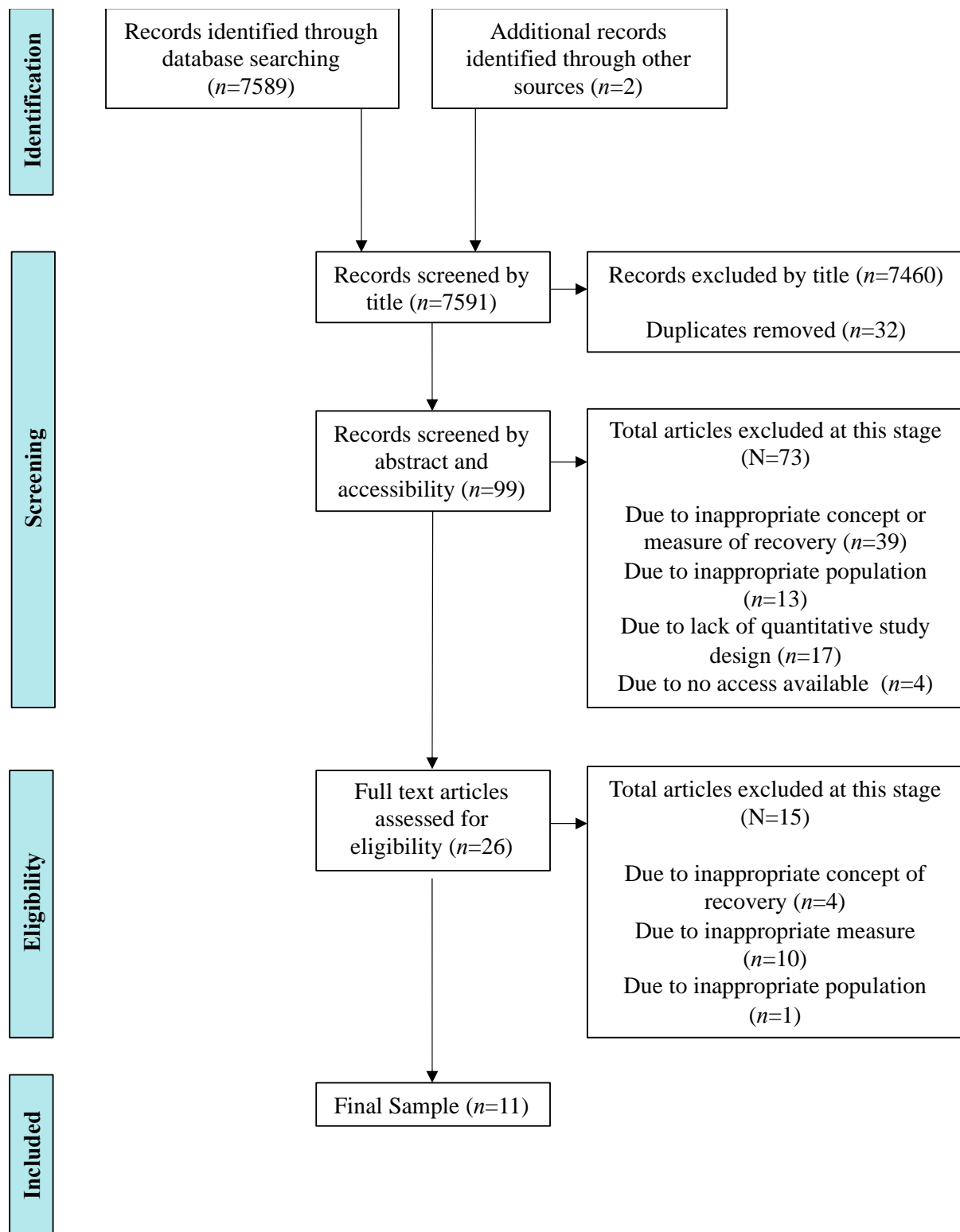


Figure 1. PRISMA diagram to illustrate the search strategy for the review.

Eligibility Criteria

The review aimed to identify papers that used a quantitative measure of personal recovery within a forensic mental health setting. Criteria for the population, measurement type, definition of recovery, and date were applied. Studies were included if they used a validated quantitative measure, specific to the construct of personal recovery, where the individual is rating their own perceived recovery, and the study was dated 2011 or later. A forensic mental health setting was defined as any individual who has been detained and/or had a history of involvement in the criminal justice system (CJS). See Table 3 for details of the inclusion and exclusion criteria and justification.

Table 3. Eligibility criteria of the review and justification.

Concept	Inclusion Criteria	Exclusion Criteria	Justification
Population	Participants must be from a ‘forensic mental health population’, defined as any individual who has been detained and/or a history of involvement in the criminal justice system	General mental health population	Recovery within a forensic mental health population has been found to have conflicts within recovery concept in general mental population due to the role of risk of recidivism. This review focuses on forensic mental health settings.
Measurement	A validated quantitative measurement	Qualitative measures	Previous systematic reviews and meta-syntheses have detailed themes of personal recovery within a forensic population (Shepherd, Doyle, Sanders & Shaw, 2016).

			To date, there is no review of quantitative measures that are used with this population.
Recovery Concept	Personal recovery	Any other defined recovery concept, including ‘clinical recovery’, ‘attitudes toward recovery’, ‘recovery service-orientation’, ‘substance-use recovery’	Personal recovery is a different concept to clinical recovery (Bellack, 2006), which is reflected in a lack of correlation in outcome measures of the different concepts (Roe, Mashiach-Eizenberg & Lysaker, 2011).
Rating of Personal Recovery	Self-reported rating of an internal state	Service users’ rating of a service, or staff rating of a service user	The definition of personal recovery recognises the “personal, unique process” (Anthony, 1993, p. 527). Due to the subjective nature, a self-reported rating is appropriate to capture the concept.
Date	2011 onwards	Dated prior to 2011	Literature published in 2011 indicated the disparity between clinical and forensic aspects of personal recovery, indicating unique difficulties in adapting recovery existing work to forensic mental health settings (Dorkins & Adshead, 2011). This year of publication also included the introduction of new

conceptual frameworks
(Leamy, Bird, Le Boutillier,
Williams & Slade, 2011;
Simpson & Penney, 2011).

Data Extraction

Data were extracted by the author. The country of origin, participant demographics, study setting and design, outcome measures, and the findings were extracted from each of the papers. See Table 4 for the extracted data.

Table 4. Data extraction of the 11 papers in the review.

Author and Date	Country	Participant Demographics	Recovery Measure	Other Measures	Study Setting	Study Design	Summary of Findings <i>Specific to Personal Recovery</i>
Ahmed et al., 2015	USA	<i>N</i> = 78 (87.1% male, 12.9% female) Age <i>M</i> = 40.51 44.8% from mental health programme 55.2% from forensic programme 50% African American, 38.4% White, 6.4% Latin/Hispanic, 5.1% Other Schizophrenia – 54 (69%) Schizoaffective disorder – 24 (31%)	MARS	WAIS, PANSS, UPSA	Inpatient Setting. Psychiatric hospital.	Randomised Controlled Trial (secondary outcome)	The cognitive remediation intervention has no significant effect on ‘experiential recovery’ (<i>p</i> =.413).
Bartholomew et al., 2018	USA	<i>N</i> =234 (59.4% male, 37.6% female, 1.3% transgender) No age provided by authors. 88.9% had a history of criminal justice involvement	RAS-41	Behavioural and Criminal History Form, BSI, PICTS-L-SF	Community setting. Programs provided by a psychiatric rehabilitation agency.	Cross-sectional	The RAS overall accounted for 7.6% of the variance in general criminal thinking. Of the RAS domains, there was a significant predictive effect of the domain ‘personal confidence’ and ‘hope’ with

43.9% White, 33.5%
African American, 9.1%
Latin/Hispanic, 7%
American Indian or Alaska
Native, 0.4% Asian, 0.4%
Native Hawaiian or Pacific
Islander, 4.4% Other 1.3%
Declined to Respond
Schizoaffective disorder –
64 (27.4%)
Schizophrenia – 39 (16.7%)
Other psychotic disorder –
11 (4.7%)
Bipolar – 45 (19.2%)
Major depressive disorder –
31 (13.2%)
Other mood disorder – 13
(5.6%)
PTSD – 5 (2.1%)
General/social anxiety
disorder – 3 (1.3%)
Other psychiatric disorder –
9 (3.8%)

general criminal thinking
($p=.035$).
The interaction between
program type and RAS
subscales was non-significant
($p= .924, .410, .619, .649,$
.228).

Bond et al., 2015	USA	<p><i>N</i>= 87 (79.3% male, 20.7% female) Age <i>M</i>= 43.75 29.8% White, 58.6% African American, 9.1% ≥2 races, 2.2% Other, 12.6% Hispanic Schizophrenia – 46 (52.8%) Depressive disorder – 16 (18.3%) Bipolar disorder – 22 (25.2%) Other – 3 (3.4%)</p>	RAS-24	Dartmouth Vocational Update Form	Community setting. Programs provided by a psychiatric rehabilitation agency.	Randomised Controlled Trial (secondary outcome)	<p>No difference of self-reported recovery between IPS (4.14 ± .57) and Work Choice (4.14 ± .49) at 12 months. No change in recovery from baseline to follow up (no statistics reported).</p>
Compton et al., 2016	USA	<p><i>N</i>= 100 (53% male, 47% female) Age range 18-65 (<i>M</i>= 37.3) 52% White, 46% African American, 2% Other Psychotic disorder – 46 (46%) Mood disorder – 54 (54%)</p>	MHRM	MCAS-P, QOLI, DLA Scale, Opening Doors to Recovery constructs, PANNS	Community setting. Programs provided by a psychiatric rehabilitation agency following discharge from a	Cohort study (primary outcome)	<p>Non-significant linear trend (improvement) in recovery scores (<i>p</i>=.056). An increase from baseline at 4 months (<i>p</i>=.059), 8 months (<i>p</i>=.215), and 12 months (<i>p</i>=.20) was found.</p>

					psychiatric hospital or crisis stabilisation unit.		
Jas and Wieling, 2018	Netherlands	N= 127 (80.3% male, 19.7% female) Age range 21-69 (M= 42.2) No ethnicity given. Schizophrenia or Psychotic disorder – 78 (61.4%) Anxiety or mood disorder – 18 (14.2%) Substance abuse – 104 (81.9%) ADHD – 12 (9.4%) ASD – 9 (7.1%) Sexual disorder – 16 (12.6%) Personality disorder – 60 (47.2%) Mental retardation – 30 (23.6%)	QPR	RPRS	Inpatient Setting. High secure psychiatric hospital	Cohort study (primary outcome)	Personal recovery was found to be significantly associated with provider's recovery competence ($p<.001$). An increase in personal recovery over time is positively influenced by a higher provider's competence score ($p=.02$). If personal recovery is high at baseline, there is less improvement at the second time point (6 months) ($p<.001$).

Livingston et al., 2013	Canada	<p><i>N</i>= 30 (80% males, 20% females)</p> <p>Age <i>M</i>= 40</p> <p>87% White (no other ethnicities given)</p> <p>Schizophrenia – 18 (60%)</p> <p>Schizoaffective disorder – 5 (17%)</p> <p>Bipolar disorder – 3 (10%)</p> <p>Other psychotic disorder – 2 (7%)</p> <p>Unknown – 2 (7%)</p>	MHRM	<p>Recovery Self-Assessment Scale (recovery orientated care), EssenCES, SOLES, MDES, ISMI</p>	<p>Inpatient Setting. Forensic Mental Health hospital – for those with severe mental illness who are unfit to stand for trial.</p>	<p>Cross-sectional and a pre-post study</p>	<p>Personal recovery correlated with personal empowerment ($r=.60, p<.01$) and internalised stigma ($r= -.79, p<.01$).</p> <p>Personal recovery was not significantly correlated with recovery-orientated care. Closer analysis demonstrated some correlations between subscales; RSA's life goals with MHRM basic functioning ($r=.39, p<.05$) and enrichment ($r=.43, p<.05$), RSA's involvement with MHRM's enrichment ($r=.48, p<.01$), RSA's choice with MHRM's well-being ($r=.39, p<.05$), and new potentials ($r=.37, p=.05$), and RSA's individualised with MHRM's basic functioning ($r=.43, p<.05$) and enrichment ($r=.37, p<.05$).</p> <p>No significant difference in personal recovery at T1 and T2.</p>
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							Changes in scores were statistically similar for patients with low, moderate, or high level of participation. Change in MHRM scores were not significantly associated with taking part in peer support ($r=.05, p>.05$) the patient advisory committee ($r=.22, p>.05$) or team PEER ($r=.02, p>.05$). There was a significant association between attending at least one peer support group and improvements in personal recovery ($r=.40, p=.05$).
Kopelovich et al., 2013	USA	$N= 51$ (64.7% male, 35.3% female) Age range 20-62 ($M=39.46$) 40.8% African American, 36.7% Latino, 16.3% White, 4.1% Asian, 2% Other	RAS-41	Courtroom Observation Survey, PPJ, IOH, MHC-PJ (procedural justice), CSI	Community setting. Four mental health courts.	Cohort study (primary outcome)	These results are from the MHC-PJ measure. There was a non-significant correlation between perceived procedural justice and recovery ($r=.39, p>.05$). There was an increase in recovery score at follow up,

		No diagnoses reported		(psychiatric symptoms). Only interested in MHC-PJ measure due to Pratt et al. 2013.			however this was not significantly related to changes in procedural justice ($r=-.261$, $p>.05$).
MacInnes et al., 2016	UK	<i>N</i> = 112 patients (gender only available for 96% of participants due to missing data – 81.2% male, 18.8% female) Age <i>M</i> = 35 6.5% Asian, 28.9% Black, 14.0% Mixed or Other, 50.4% White Schizophrenia and Schizoaffective disorder – 80 (71.4%) Other – 25 (22.3%)	QPR	HAS, EssenCES, FSS, MBI, DIALOG Satisfaction Checklist	Inpatient Setting. Six Medium Secure Units	Cluster Randomised Controlled Trial (secondary outcome)	Estimated treatment effects for the intrapersonal subscale of the QPR at 6 months was 2.2, and 1.7 at 12 months. Estimated treatment effects for the interpersonal subscale of the QPR at 6 months was -0.1, and -0.9 at 12 months. No significant levels reported.

Pratt et al., 2013	USA	<i>N</i> = 50 (66% male, 34% female) Age <i>M</i> = 39.44 42% Black, 36% Latino, 16% White, 6% Other No diagnoses reported	RAS-41	CSI, PPJ, IOH, MAES	Community setting. Four mental health courts.	Cohort	At baseline, recovery was negatively related to psychiatric symptoms ($r=-.199$) and perceived coercion ($r=-.235$). It was positively related to perceived procedural justice. At 12 months, only the RAS-non-domination by symptoms subscale was significantly different between those with or without further CJS involvement ($p=.027$). RAS-non-domination by symptoms, made an independent contribution to the prediction of criminal justice involvement ($p=.02$).
Sveinsdottir and Bond, 2017	USA	<i>N</i> = 87 (79% male, 21% female) Age <i>M</i> =43.75 30% White, 70% Other Schizophrenia – 46 (53%) Bipolar – 22 (25%)	RAS-24	Satisfaction with services (1 item), Barrier to Employment Checklist	Community setting. Programs provided by a psychiatric	Randomised Controlled Trial (secondary outcome) for data then	Higher scores on “non-domination by symptoms” subscale of the RAS was associated with engagement problems ($r=.028$).

Other– 19 (22%)

rehabilitation cross-
agency. sectional for
this study
analysis

Note. Abbreviations are listed below.

Maryland Assessment of Recovery in Severe Mental Illness (MARS)	Questionnaire about Process of Recovery (QPR)
Wechsler Abbreviated Scale of Intelligence Second Edition (WAIS-II)	Recovery Promoting Relationships Scale (RPRS)
MATRICES Consensus Cognitive battery (MCCB)	Recovery Self Assessment Scale (RSA) (recovery orientated care)
Positive and Negative Syndrome Scale (PANSS)	Essen Climate Evaluation Schema (EssenCES)
UCSD Performance-Based Skills Assessment (UPSA)	Singh O’Brien Level of Engagement Scale (SOLES)
Recovery Assessment Scale 41-item (RAS-41)	Making Decisions Empowerment Scale (MDES)
Brief symptom inventory (BSI)	Internalized Stigma of Mental Illness scale (ISMI)
Psychological inventory of Criminal Thinking styles–layperson edition–short Form (PiCTs-1-sF)	Perceptions of Procedural Justice scale (PPJ)
Recovery Assessment Scale 24-item (RAS-24)	Impact of Hearing (IOH)
Mental Health Recovery Measure (MHRM)	Mental Health Court-Procedure Justice (MHC-PJ)
Multnomah Community Ability Scale–Patient Version (MCAS-P)	Colorado Symptom Index (CSI) (psychiatric symptoms)
Quality of Life Inventory (QOLI)	Manchester Short Assessment of Quality of Life scale (MANSA)
Daily Living Activities (DLA) Scale	Helping Alliances Scale (HAS)
	Forensic Satisfaction Scale (FSS)
	Maslach Burnout Inventory (MBI)

Quality Appraisal

The risk of bias was assessed for each of the studies using a set of quality assessment criteria. For this process, the 10 studies have been reviewed as the 11 papers due to the different study designs applied within the Livingston et al. papers (2012; 2013). Thus, a total of 11 papers are presented. The criteria were adapted from the Cochrane Collaboration Risk of Bias Tool (Higgins et al., 2011) and the Quality Assessment Tool for Quantitative Studies (QATQS) (Effective Public Health Practice Project, 1998). It incorporates potential sources of selection bias, detection bias, generalisability, analyses, reporting bias, and attribution bias. Due to the variety of studies included, a further two areas of potential bias were included for Randomised Controlled Trials (RCTs). These were intervention integrity and confounders. For each source of bias, a rating of low, moderate, and high risk was assigned per the criterion (Table 5). With this, a rating of zero to two is given based on the risk of bias; two points for low risk, one point for moderate risk, and zero points for high risk. The total score is calculated and a final percentage providing an overall rating. Percentage ratings of <33% are considered high risk of bias, 34-66% rated moderate risk, and 67-100% rated as low risk.

Four of the 11 papers were selected at random to be independently appraised by an independent reviewer (Trainee Forensic Clinical Psychologist) to ensure inter-rater reliability of the quality appraisal process. This process was assessed using a kappa coefficient, calculated by a statistical calculator from 'GraphPad Software'¹. A kappa coefficient is a statistical test that allows you to analyse interrater agreement of categorical data. A 3x3 contingency table was used, taking the overall risk rating of each paper (low, moderate, or high risk of bias) from the two reviewers. The kappa score for agreement was 0.928 (SE=0.071), reflecting an "almost perfect agreement" (Landis & Koch, 1977).

¹ The statistical calculator used for the analysis can be found at <https://www.graphpad.com/quickcalcs/kappa1/?K=3>

Table 5. Risk ratings summaries for the 11 papers.

Component Ratings	Papers										
	Ahmed et al., 2015	Bartholomew et al., 2018	Bond et al., 2015	Compton et al., 2016	Jas & Wieling, 2018	Livingston et al., 2012	Livingston et al., 2013	Kopelovich et al., 2013	MacInnes et al., 2016	Pratt et al., 2013	Sveinsdottir & Bond, 2017
<i>Selection Bias</i>	Green				Orange			Green	Orange		
<i>Detection Bias</i>	Orange	Green	Orange	Green					Orange	Green	Orange
<i>Generalisability</i>	Orange	Green	Orange	Green	Orange				Green	Orange	
<i>Analyses</i>	Green						Red	Green	Red	Green	
<i>Reporting Bias</i>	Green		Orange	Green			Orange				Green
<i>Attrition Bias</i>	Green		Orange	Green			Orange		Green		Red
For randomised controlled trial studies.											
<i>Intervention Integrity</i>	Green	N/A	Green	N/A	N/A	N/A	N/A	N/A	Green	N/A	N/A
<i>Confounders</i>	Green	N/A	Red	N/A	N/A	N/A	N/A	N/A	Red	N/A	N/A
Overall Rating	87%	100%	63%	100%	92%	92%	50%	50%	75%	58%	58%

Note. Green indicates low risk of bias; orange indicates moderate risk of bias, and red indicates high risk of bias as demonstrated in the quality criteria in Appendix B. Details of the justification in the rating can be found in Appendix C.

Selection Bias

Six of the studies; Ahmed et al. (2015), Bartholomew et al. (2018), Bond et al. (2015), Compton et al. (2016), Jas and Wieling (2018), and MacInnes et al. (2016) were found to be at low risk of selection bias. Three studies, Kopelovich et al. (2013), Pratt et al. (2013), and Sveinsdottir and Bond (2017), were of moderate risk. All RCT studies (Ahmed et al.; 2015 Bond et al., 2015; MacInnes et al., 2016) demonstrated low risk by randomising the allocation to group. All studies except Sveinsdottir and Bond (2017) provided adequate participant characteristics to assess pre-existing characteristic differences at baseline between participant groups. The Livingston et al. (2013) study was noted to be at low risk of selection bias in the cross-sectional design (2012), however of moderate risk for the pre-post study design (2013).

Detection Bias

Six of the studies were found to be at low risk; Bartholomew et al. (2018), Compton et al. (2016), Jas and Wieling (2018), Livingston et al. (2013), Kopelovich et al. (2013), and Pratt et al. (2013). Both study designs within the Livingston et al. (2013) study were considered low risk. These studies provided relevant details of the measures used. Lower ratings were given where information was missing. Of the four studies that were found to have a moderate risk of detection bias, Bond et al. (2015) and Sveinsdottir and Bond (2017) provided the author and subscales details but reported no reliability and validity details. This included the absence of Cronbach alpha. MacInnes et al. (2016) reported details for the primary measure only and excluded these details of the recovery measure. Ahmed et al. (2015) provided a list of measures only.

Generalisability

Seven of the studies were found to be at moderate risk of bias generated from lack of generalisability; Ahmed et al. (2015), Bond et al. (2015), Jas and Wieling (2018), Livingston et al. (2012), Livingston et al. (2013), Kopelovich et al. (2013), Pratt et al. (2013), and Sveinsdottir and Bond (2017). Both study designs within the Livingston et al. (2013) study were considered of moderate risk. All moderate ratings were due to possible idiosyncratic features of the participants. Bartholomew et al. (2018), Compton et al. (2016) and MacInnes et al. (2016) were rated as being low risk due to sufficient sample size and recruiting from multiple services and locations.

Analyses

Seven of the studies were found to be at low risk of bias in the analysis; Ahmed et al. (2015), Bartholomew et al. (2018), Bond et al. (2015), Compton et al. (2016), Jas and Wieling (2018), MacInnes et al. (2016) and Sveinsdottir and Bond (2017). Kopelovich et al. (2013) and Pratt et al. (2013) were rated high risk due to reporting reduced statistical power following post-hoc power calculations. Livingston et al. (2013) was considered low risk of bias in the analysis when using a cross-sectional design, however due to reported reduced statistical power for the pre-post study, the 2013 paper was considered at high risk.

Reporting Bias

Five of the studies were found to be at low risk; Ahmed et al. (2015), Bartholomew et al. (2018), Compton et al. (2016), Jas and Wieling (2018), and Sveinsdottir and Bond (2017). Four studies were rated to be of moderate risk of reporting bias. Kopelovich et al. (2013), and Pratt et al. (2013) removed the data from participants who withdrew from the analyses and reporting. MacInnes et al. (2016) removed participants from the analysis due to missing data. Bond et al. (2015) was considered at moderate risk due to insufficient reporting of the results.

The Livingston et al. (2013) study was considered low risk of reporting bias with the cross-sectional design, however of moderate risk in the pre-post study due to removing withdrawals' data from the analyses and reporting.

Attrition Bias

Six of the studies were found to be at low risk of attrition bias; Ahmed et al. (2015); Bartholomew et al. (2018), Compton et al. (2016), Jas and Wieling (2018), MacInnes et al. (2016) and Pratt et al. (2013). Bond et al. (2015) and Kopelovich et al. (2013) were considered of moderate risk due to failure to provide a comparison of demographic information of study participants and those who withdrew. Sveinsdottir and Bond (2017) did not provide any information on those who withdrew from the study, and therefore was considered to be high risk. Livingston et al. (2013) was found to be of low risk when using the cross-sectional design, but of moderate risk of attrition bias when using a pre-post design due to not reporting the demographic information of study participants and those who withdrew.

Intervention Integrity

Ahmed et al. (2015), Bond et al. (2015) and MacInnes et al. (2016) were examined for intervention integrity. All three studies were found to be at low risk of bias due to taking a minimum of two measures to ensure intervention integrity. Ahmed et al. (2015) took measures to ensure intervention adherence, program differentiation and exposure. Bond et al. (2015) ensured intervention adherence and participant responsiveness. Whilst MacInnes et al. (2016) safeguarded procedures for intervention adherence, program differentiation and quality of delivery.

Confounders

Ahmed et al. (2015), Bond et al. (2015) and MacInnes et al. (2016) were examined for confounders. Ahmed et al. (2015) was considered at low risk due to presenting demographic and clinical characteristics of the participants and group matching. Bond et al. (2015) and MacInnes et al. (2016) were at high risk due to no reported considerations of confounders on the study.

Data Analysis

A narrative synthesis was used to analyse the data; defined as a method “that relies primarily on the use of words and text to summarise and explain... it adopts a textual approach to the process of synthesis to ‘tell the story’ of the findings” (Popay et al., 2006, p. 5). This method was selected due to clinical, methodological, and statistical heterogeneity across studies. Alternative methodologies, such as a meta-analysis, were inappropriate as it may be misrepresentative to provide an average value for the intervention effect given such heterogeneity.

The current review aims to ‘tell the story’ of how personal recovery measures are currently used in forensic mental health settings. Data from the papers address the aims by identifying which measures are used before examining the study designs, settings, and participant characteristics to consider how they are applied. Their findings are also considered to evaluate if the measures are applied beneficially.

Results

Personal Recovery Measures

Four measures of personal recovery were found to be used in the 10 studies. A description of each measure is reported in Table 6. The most employed measure in the review

was the Recovery Assessment Scale (RAS); utilised in five of the studies (Bartholomew et al., 2018; Bond et al., 2015; Kopelovich et al., 2013; Pratt et al., 2013; Sveinsdottir & Bond, 2017).

All measures, bar the Mental Health Recovery Measure (MHRM), were developed from a clinical population. The MHRM was developed with data of mental health consumers² in a variety of inpatient, forensic and community mental health settings. The RAS used a sample of individuals with severe mental illness accessing community services. The Questionnaire about Process of Recovery (QPR) was developed with a sample of individuals with psychosis accessing community services. The Maryland Assessment of Recovery in Serious Mental Illness (MARS) was developed with a sample of individuals diagnosed with schizophrenia or schizoaffective disorder, bipolar I disorder, or major depression with psychotic features in the community.

The RAS consists of 41 items; however, further revisions of the measure have produced versions with reduced numbers of items. Those found in the review were the RAS-41 and RAS-24. The original measure was developed from participatory action research and narrative analysis, which were then reviewed by an independent group of 12 consumers³ (Giffort et al., 1995). The RAS-24 was developed by Corrigan et al. (2004) following a factor analysis of the RAS-41. Five factors were found, comprising 24 items.

In the current review, three studies used the RAS-41 with a total participant number of 335 (Bartholomew et al., 2018; Kopelovich et al., 2013; Pratt et al., 2013) and two studies used the RAS-24 with 174 participants (Bond et al., 2015; Sveinsdottir & Bond, 2017). All studies that used the RAS-41 reported the internal consistency, with Cronbach's Alpha

² The term 'consumer' is used by the authors of the MHRM and refers to service users of the inpatient, forensic and community mental health settings.

³ The term 'consumer' has been used by the authors of the measure and refers to service users of mental health services.

ranging between .85 and .95. Those that used the RAS-24 did not report any psychometric properties.

The MHRM was present in two studies, across 130 participants (Compton et al., 2016; Livingston et al., 2013). These studies reported internal consistency, with Cronbach's Alpha ranging between .82 and .90.

The QPR was published in two studies (Jas & Wieling, 2018; MacInnes et al., 2016). The total number of participants was 239. Neither study reported the internal consistency.

The MARS was used in one study, which recruited 78 participants (Ahmed et al., 2015). The study does not report any psychometric properties of the measure.

Table 6. Personal recovery measures found in the review

Measure	Authors	Details
Maryland Assessment of Recovery in Serious Mental Illness (MARS)	Drapalski, Medoff, Unick, Velligan, Dixon and Bellack (2012)	25-item self-report instrument that measures recovery of people with serious mental illness. It consists of six domains; self-direction or empowerment, holistic, nonlinear, strengths-based, responsibility, and hope.
Recovery Assessment Scale (RAS)	Giffort, Schmook, Woody, Vollendorf and Gervain (1995) Corrigan, Salzer, Ralph, Sangster & Keck, 2004)	41-item self-report measure. Following a factor analysis, five domains were found from 24 items. The five domains are personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no dominance of symptoms. Further development has generated multiple versions. In this review the RAS-41 and RAS-24 were used.
Mental Health Recovery Measure (MHRM)	Young and Bullock (2003)	41-item measure which was later revised to 30-items (Bullock & Young, 2005). It uses a 5-point Likert scale and includes seven domains; overcoming stuckness, self-empowerment, learning and self-

		redefinition, basic functioning, overall well-being, new potentials, and advocacy and enrichment.
Questionnaire about Process of Recovery (QPR)	Neil, Kilbride, Pitt, Nothard, Welford, Sellwood and Morrison (2009)	22-item measure. It comprises of intrapersonal and interpersonal subscales. The QPR was shown to have internal consistency, construct validity and reliability. A further 15-item measure has been created, which equally demonstrates good psychometric properties (Law, Neil, Dunn & Morrison, 2014; Williams, Leamy, Pesola, Bird, Le Boutillier & Slade, 2015). Higher scores are indicative of recovery.

Sample Characteristics

The studies recruited a total sample of 956 participants; 71% (n= 681) were male. The medium value for the mean age of participants was 40 years (IQR=42.2-39.44). Bartholomew et al. (2018) did not report a mean age for the sample, therefore, was excluded in the calculation. The studies took place across four different countries; seven in the USA (Ahmed et al., 2015; Bartholomew et al., 2018; Bond et al., 2015; Compton et al., 2016; Kopelovich et al., 2013; Pratt et al., 2013; Sveinsdottir & Bond, 2017), one in Canada (Livingston et al., 2013), one in the Netherlands (Jas & Wieling, 2018), and one in the UK (MacInnes et al., 2016). The ethnicity of participants is reported in all but one study: Jas and Wieling (2018). Of those which reported ethnicity, 41% of participants in the review were White, 33% African American/ Black, 12% Other, 9% Latin/Hispanic, 2% American Indian or Alaska Native, 1% Asian, <1% Native Hawaiian or Pacific Islander, <1% ≥2 races, and <1% declined to respond.

Study Setting

Four of the studies were conducted in psychiatric hospital inpatient settings. One of which was within medium secure units (MacInnes et al., 2016), and one in a high secure setting (Jas & Wieling, 2018). Ahmed et al. (2015) and Livingston et al. (2013) did not report security level. Six of the studies were conducted in the community, two in mental health courts (Kopelovich et al., 2013; Pratt et al., 2013) and four through programs facilitated by community psychiatric rehabilitation agencies (Bond et al., 2015; Bartholomew et al., 2018; Compton et al., 2016; Sveinsdottir & Bond, 2017).

Study Design

Three studies applied a randomised controlled trial (RCT) design (Ahmed et al., 2015; Bond et al., 2015; MacInnes et al., 2016). In all three of these studies, the personal recovery measure was used as a secondary outcome.

Ahmed et al. (2015) evaluated a cognitive remediation intervention for individuals with schizophrenia and schizoaffective disorder, with the MARS as a measure of 'psychosocial status', alongside the UCSD Performance-Based Skills Assessment. The study also took measures of clinical status, and neurocognition, and demographic data. These were administered at baseline and post-intervention, either a 50-hour treatment or a control group.

Bond et al. (2015) compared the effectiveness of two contrasting employment interventions; conducting measures and interviews at baseline, six months, and 12 months of intervention. The RAS-24 was used as a measure of 'self-reported recovery'. Objective employment was also measured, and the number of psychiatric hospitalisation admissions and involvement with the CJS.

MacInnes et al. (2016) followed a cluster RCT design and evaluated a 'structured patient-clinician communication approach' intervention to facilitate negotiations between patient and clinician. Participants were randomised to the intervention or treatment as usual

group. The primary outcome was quality of life, with secondary outcomes measuring engagement with services, ward climate, patient satisfaction, recovery, nurse stress, and 'disturbed' behaviour. Measures were taken at baseline, six months, and 12 months.

Four of the studies used a cohort design, all employing personal recovery as a primary outcome (Compton et al., 2016; Jas & Wieling, 2018; Kopelovich et al., 2013; Pratt et al., 2013). Compton et al. (2016) examined institutional recidivism and recovery following the 'Opening Doors to Recovery' programme. Participants previously enrolled in the programme for 12 months were recruited. Recovery was measured by primary recovery measures and secondary recovery measures. Primary measures included the MHRM as a measure of 'mental health recovery', the Multnomah Community Ability Scale-Patient Version for 'community functioning', and Quality of Life Inventory for 'quality of life'. The secondary recovery measures were completed by a management team that provided case management and recovery support. These were measures of functioning, adequate treatment, meaningful days, safe housing and use of technology. The construct of total positive, negative, and general psychopathology symptom severity was also measured, and lifetime arrests. Measures were administered at baseline, four months, eight months, and 12 months.

Jas and Wieling (2018) examined the effect of mental healthcare providers' recovery-promoting competencies on personal recovery. A Dutch translation of the QPR was made to measure personal recovery. The authors also added four items for concept mapping. The Recovery Promoting Relationships Scale was used to capture the competencies of professionals to promote recovery from the patient's perspective. Items from the Health of the Nation Outcome Scales were used as confounding variables.

Kopelovich et al. (2013) assessed perceived procedural justice and recovery for individuals attending a Mental Health Court (MHC). Measures were taken at baseline, where participants were newly enrolled at a MHC and four months later. Procedural justice was

measured by researcher observation and two self-report measures completed by participants. Observations were scored using the Courtroom Observation Survey, designed to gather information relevant to assess procedural fairness, respect, warmth, familiarity, inclusion, and absence of coercion. Self-report measures were used to assess thematic components of procedural justice. The RAS-41 was used to assess recovery.

Pratt et al. (2013) also assessed how recovery related to criminal justice outcomes. Perceived recovery, psychiatric symptoms, procedural justice and perceived coercion were measured. Perceived recovery was measured by the RAS-41. Procedural justice was measured by self-report questionnaires assessing thematic components of procedural justice. An adapted self-report measure assessed perceived coercion. Criminal justice involvement was collated by data from state records examining arrests and jail and prison episodes.

Two studies used a cross-sectional design (Bartholomew et al., 2018; Sveinsdottir & Bond, 2017). Bartholomew et al. (2018) examined the relationship between recovery, criminal thinking, and program type. Participants attended either the Assertive Community Treatment (ACT) or Forensic Assertive Community Treatment (FACT) programmes. The RAS-41 assessed self-reported recovery, with additional measures of self-reported distress, criminal thinking styles and a behavioural and criminal history form developed for the research, also administered.

Sveinsdottir and Bond (2017) used data from an RCT design to compare the effectiveness of two interventions to aid employment. However, they applied a cross-sectional design to examine associations between measures. Measures of self-reported recovery, satisfaction with services, and barriers to employment were used. Demographic information and background information of employment history, income status, and CJS history were also gathered.

Livingston et al. (2013) contains two different study designs, published in two papers. The 2012 paper used a cross-sectional design to examine the relationship between recovery, measured by the MHRM, and recovery-orientated care, therapeutic milieu, empowerment, engagement and internalised stigma. All measures were administered to patient-participants, whilst measures of recovery-orientated care and therapeutic milieu were also administered to staff-participants for comparison. The study also used a pre-post study design, as published in the 2013 paper. This research evaluated a patient engagement intervention with no control group. The intervention consisted of three components; a peer support program, a patient advisory committee, and a peer research team. Measures of personal recovery, recovery orientated care, therapeutic milieu, empowerment, engagement and internalised stigma were taken at two time points—the first 'near the beginning' of the intervention and nine months later.

Summary of Findings

Analysis of Variance

Ahmed et al. (2015) used Multivariate Analysis of Covariance (MANCOVA) models to compare baseline scores of mental health and forensic mental health patients on the outcome measures. Regarding recovery, there was no multivariate difference between participants (Wilk's $\lambda = 0.92$, $F(8,138) = 0.427$, $p = 0.903$). Mixed model MANCOVA models were used to compare cognitive remediation and control groups on primary and secondary outcome measures. The multivariate treatment group-by-time effect on MARS subscales was not significant (Wilk's $\lambda = 0.458$, $F(4,73) = 1.61$, $p = 0.413$, $\eta^2 = 0.002$, Observed Power = 0.75). Thus, it was non-congruent with the hypothesis that the cognitive remediation patients would have greater scores on measures of psychosocial functioning.

Pratt et al. (2013) completed a bivariate analysis to find which variables were associated with further criminal justice involvement. Regarding personal recovery, only the subscale 'non-domination by symptoms' on the RAS-41 was significantly different between those with or without further CJS involvement at 12 months ($F(1, 47) = 5.22, p = .027$).

Analysis of Means

Bond et al. (2015) hypothesised that IPS participants would have higher levels of self-reported recovery at follow up. Due to skewed distributions, the Mann-Whitney test was used. The RAS did not differ between IPS ($4.14 \pm .57$) and Work Choice ($4.14 \pm .49$) participants at 12 months. There were no changes from baseline to follow up for either group. However, no statistics are reported for this analysis. The hypothesis was unsupported.

Livingston et al. (2013) used *t*-tests to compare the outcome measures taken before and after the intervention. They report that no statistically significant difference was found in personal recovery across the two time points. However, the *t*-test for this was unreported. Changes in scores were statically similar for patients with low, moderate, or high level of participation in the intervention ($F(2, 23) = 0.89, p > .05$). Changes in personal recovery scores were not significantly associated with engagement in any of the three types of interventions: peer support ($r = .05, p > .05$), the patient advisory committee ($r = .22, p > .05$) or team PEER ($r = .02, p > .05$). Nevertheless, there was a significant association between attending at least one peer support group and improvements in personal recovery ($r = .40, p = .05$).

MacInnes et al. (2016) estimated treatment effects and confidence intervals for each outcome measure at the different time points. The authors report that no formal sample size calculation was carried out due to being a pilot study, consequently, the study was underpowered and could not calculate statistical significance. Estimated treatment effects on

the QPR at six months were 2.2 (CI= -2.3 to 6.7) for the Intrapersonal subscale and -0.1 (CI= -1.3 to 1.2) for the Interpersonal subscale. At 12 months, the estimated treatment effect on the QPR were 1.7 (CI= -0.7 to 4.1) for the Intrapersonal subscale and -0.9 (CI= -2.7 to 1.0) for the Interpersonal subscale. The authors report that no firm conclusions could be made from these estimates about the effectiveness of the intervention on self-reported personal recovery.

Sveinsdottir and Bond (2017) explored the associations between the common barriers to employment and recovery using independent sample t-tests. A relationship was found between the RAS subscale of 'non-domination by symptoms' and engagement problems ($t(85)=2.70, p=0.01$).

Regression

Bartholomew et al. (2018) hypothesised that positive attitudes towards psychiatric recovery would be negatively associated with criminal thinking, and this would be moderated by programme type. Linear regression analyses found a significant main effect of the 'Personal Confidence and Hope' RAS scales ($b = -0.46, p = .035$). However, all main effects accounted for only 7.6% of the variance in General Criminal Thinking. Interactions between programme type and the RAS scales accounted for a further 2.7% of the variance in General Criminal Thinking. The hypothesis was partially supported by a significant negative effect between the 'Personal Confidence and Hope' RAS scales and General Criminal Thinking. Contrary to the hypothesis, these associations did not vary between ACT and FACT program participants.

Compton et al. (2016) examined the effects of the 'Opening Doors to Recovery' programme. A linear mixed model, with time as a factor, was used to estimate separate time points for the measures. A customised hypothesis test of the model coefficients was then applied to assess significant changes from baseline and possible linear trends, with a non-

significant linear trend in MHRM scores ($p=.056$) found. There were no significant differences in personal recovery from baseline to 4 months ($p=.059$) or eight months ($p=.215$). However, a significant difference between recovery scores from baseline to 12 months was found ($p=.020$).

Jas and Wieling (2018) hypothesised that higher recovery-promoting competencies of professionals would be associated with a higher degree of personal recovery. A linear mixed-effects regression (LMER) analysis was used with participant as a random-effect factor. Providers' recovery-promoting competence was significantly related to personal recovery ($\beta= .45$, $t= 8.4$, $p<.001$). It was further hypothesised that higher recovery-promoting competencies of professionals would be associated with greater improvement in personal recovery over time. This hypothesis was examined with a LMER using the difference in personal recovery scores over time and the difference in competence scores over time as predictors. Provider's competency at baseline has a statically significant positive impact on the improvement in personal recovery over time ($\beta= .15$, $t=2.3$, $p= .02$). Furthermore, the difference between recovery-promoting competence over time has an additional positive effect ($\beta= .29$, $t=4.6$, $p<.001$). Finally, the authors report that if personal recovery scores were high at baseline, there was significantly less improvement in personal recovery at the second time point at six months ($\beta= -.35$, $t=5.1$, $p<.001$). This result can be anticipated as there may be reduced scope for an increase in personal recovery for individuals who previously report high levels at the first time point. The results could also be impacted by possible ceiling effects of the QPR in which individuals may be scoring at, or near, the upper limit of the measure.

Correlation

Four of the studies examined the relationship of personal recovery with other concepts. The additional measures used within these studies for the analysis can be found in Table 7.

Table 7. Measures used to examine correlations with additional constructs

Study	Psychological Construct	Measure	Personal Recovery Measure Used in Study
Livingston, Nijdam-Jones, and Brink (2012)	Personal empowerment	Making Decisions Empowerment Scale (Rogers, Chamberlin, Ellison, & Crean, 1997)	Mental Health Recovery Measure (MHRM)
	Internalised stigma	Internalized Stigma of Mental Illness scale (Ritsher, Otilingam, & Grajales, 2003)	
	Recovery-orientated care	Recovery Self Assessment Scale (O’Connell, Tondora, Croog, Evans, & Davidson, 2005)	
Kopelovich, Yanos, Pratt and Koerner (2013)	Perceived procedural justice	Perceptions of Procedural Justice scale (Poythress, Petrila, McGaha & Boothroyd, 2002)	Recovery Assessment Scale (RAS- 41)
Pratt, Koerner, Alexander, Yanos and Kopelovich (2013)	Psychiatric symptoms	Colorado Symptom Index (Shern, Wilson, Coen, Patrick, Foster, Bartsch & Demmler, 1994)	Recovery Assessment Scale (RAS-41)
	Perceived coercion	MacArthur Admission Experience Survey: Short Form (Gardner, Hoge, Bennett, Roth, Lidz, Monahan & Mulvey, 1993)	

Livingston et al. (2013) used bivariate correlations to investigate the relationships between patient-centred measures within the cross-sectional study design. A significant relationship was found between personal recovery and personal empowerment ($r=.60, p<.01$) and internalised stigma ($r= -.79, p<.01$). Thus, higher levels of self-reported personal recovery were correlated with greater empowerment and less internalised stigma. Patient's rating of recovery-orientated care was not significantly correlated with personal recovery. This is, the degree patients rated the service to align with principles of the recovery model was not related to their self-reported personal recovery. The relationship between subscales for each of the measures was also examined to investigate this further. Significant relationships were found between the recovery-orientated care measure's subscale 'life goals' with the MHRM's 'basic functioning' ($r=.39, p<.05$) and 'enrichment' ($r=.43, p<.05$). This was also found between the recovery-orientated care measure's subscale 'involvement' with the MHRM's 'enrichment' ($r=.48, p<.01$), as well as the recovery-orientated care measure's subscale 'choice' with the MHRM's 'well-being' ($r=.39, p<.05$) and 'new potentials' ($r=.37, p=.05$). Finally, the recovery-orientated care measure's subscale 'individualised' with the MHRM's 'basic functioning' ($r=.43, p<.05$) and 'enrichment' ($r=.37, p<.05$).

Kopelovich et al. (2013) used a correlation matrix to examine relationships between outcome measures. At baseline, there was a non-significant relationship between self-reported personal recovery and perceived procedural justice ($r=.39, p>.05$). Furthermore, over time, increases in personal recovery were not related to changes in procedural justice ($r=-.261, p>.05$).

Pratt et al. (2013) found, at baseline, personal recovery was negatively related to psychiatric symptoms, as measured by the CSI ($r=-.199$, $p<.05$). Personal recovery was also positively related to perceived coercion, measured by the MAES ($r=-.235$, $p<.05$).

Discussion

The current review aimed to develop knowledge of which personal recovery measures are used within forensic mental health settings, if there is validity to their use in this setting, and how these studies contribute to the evidence base. A total of 10 studies were identified in the review, demonstrating use of the measures. The results are considered in line with the aims of the review.

What Measures of Personal Recovery Are Used Within Forensic Mental Health

Settings?

The review found a total of four quantitative measures of personal recovery used within forensic mental health settings. This considerably contrasts with the known number of published personal recovery measures. Literature indicates there may be up to 35 published measures of personal recovery to date (Moreno & Uriarte, 2019). The disparity between the number of measures used in the different populations may reflect fewer published studies examining personal recovery within forensic mental health populations. It also raises concerns regarding the variability in how the construct is operationalised.

Only one measure in the review, the MHRM, was developed using a sample of clinical and forensic populations. All others were developed with a clinical sample. Thus, no specific measure for forensic mental health populations was found. Despite the MHRM being the only measure to include a forensic population in its development, the most frequently administered measure in a forensic mental health setting was the RAS. The RAS was

administered in five out of the 11 studies, including the RAS-41 and the RAS-24 versions. This is concurrent with the broader literature. A review of the RAS in 2014 found this to be the most widely used measure of personal recovery, with the majority of published studies using the RAS-41 or RAS-24. However, further variations such as the RAS-20, RAS-22, RAS-42, and RAS-50 have also been applied (Salzer & Brusilovskiy, 2014).

The current review records the MHRM as the second most frequent in the forensic mental health literature, published in three studies, followed by the QPR in two studies, and finally, the MARS, published in one. A systematic review in clinical settings (Sklar et al., 2013) also noted the MHRM to be frequently published, suggesting consistency across the different fields of literature. However, Shanks et al. (2013) and Sklar et al. (2013) also report the Illness Management and Recovery (IMR) scale to be widely published; Shanks reporting this to be the second most frequently published in their review. This review did not identify this measure within forensic mental health settings. The IMR scale was developed to assess specific outcomes of the IMR program for individuals with a diagnosis of schizophrenia. The measure consists of a self-report scale and clinician scale (Mueser et al., 2005) and has good psychometric properties, including appropriate internal consistency and test-retest correlations (Färdig et al., 2011). The absence of this measure highlights differences between settings, with the suitability for forensic mental health settings currently unknown.

How Are Personal Recovery Measures Used in Forensic Mental Health Settings?

The current review has demonstrated the use of personal recovery measures across several designs and analyses. The measures have been used to assess interventions (n=5), including those which, directly and indirectly, target recovery. Studies that applied interventions specifically addressing recovery reported at least one statistically significant calculation in their results (Compton et al., 2016; Livingston et al., 2013). Studies that

implemented personal recovery as a secondary measure reported non-significant results despite demonstrating significant changes in primary measures. (Ahmed et al., 2015; Bond et al., 2015; MacInnes et al., 2016). Thus, the non-significant results are not explained by a lack of change in the primary measure which may have implied an ineffective intervention. Instead, this may suggest how personal recovery measures are used within the study's design is noteworthy. Change in personal recovery may be unable to be achieved or captured through outcome measures when not directly targeted. Alternatively, a lack of change in personal recovery as a secondary measure could also be due to a delay in change between the primary and secondary measures. It may be that for an individual to self-report change in personal recovery, the benefit from an intervention as highlighted in the primary measure, may have to be experienced for longer time periods than the current studies allowed for.

The review also illustrates the successful application of personal recovery measures to examine relationships between personal recovery and other constructs in a forensic mental health setting (n=6). These relationships have been examined at a fixed time point (Bartholomew et al., 2018; Sveinsdottir & Bond, 2017; Livingston et al., 2013; Pratt et al., 2013) and over time and intervention (Jas & Wieling, 2018; Kopelovich et al., 2013).

To further examine the use of the measures, the sample population should also be considered. Wider literature suggests an over-representation of black and minority ethnic (BAME) individuals in forensic settings (Denzel et al., 2018; Leese et al., 2006; Perry et al., 2013). Consequently, the current studies' participants should be reflective of this population. Whilst the largest ethnicity across all studies was reported to be 'White' (44% of participants), BAME individuals were present, with a third of the participants reported being 'African American/ Black' (33%).

It is also well documented there is a higher prevalence of males to females in forensic settings, with some research indicating male admissions to secure specialist services as 5.6

times that of females (Coid et al., 2000). The studies within the current review total 71% of participants to be male. The samples appear to be expected for a representative sample for the four countries the studies were conducted in: the USA, Canada, Netherlands, and the UK.

The studies also illustrate the use of the measures across settings, including secure inpatient units, community services, and mental health courts. Whilst no studies conducted in a prison setting met the inclusion criteria for the review, CJS involvement was captured in mental health courts settings. The settings demonstrate appropriate generalisability for the findings to a forensic mental health setting. However, applicability to a prison setting should be considered with caution.

The most prevalent diagnoses in the review consisted of Schizophrenia, Schizoaffective disorder, and a Psychotic disorder (49.5%). This accurately reflects forensic mental health settings, with schizophrenia identified as the most common diagnosis in secure mental health settings (Völlm, 2017). Comorbidity with substance misuse is also reflected in the broader literature (Isherwood & Brooke, 2001) and equally found in this review. However, personality disorder diagnoses are reported in one study only (Jas & Wieling, 2018), despite a known prevalence in forensic settings (Bebbington, 2017; Kasmi, 2020; Pilgrim & Mann, 1990). Still, there are no reports of exclusion due to a personality disorder diagnosis in any of the studies found in the current review. The acknowledgement of personality disorder is significant, given prior literature contending the suitability of the recovery model to personality disorder diagnoses due to the differences between personality disorder and mental health difficulties (Turner et al., 2011). This review is limited in its ability to contribute to this discussion.

What Have the Personal Recovery Measures Found?

The review found five intervention studies. Two of which assessed recovery specific interventions and used the MHRM as a measure. The studies applied interventions containing

peer support; through integrating peer-led programs and family-focused services (Compton et al., 2016) and a patient engagement intervention and peer support program (Livingston et al., 2013). Overall, the results suggest the potential benefit of interventions to increase personal recovery in a forensic mental health setting. It is hypothesised that peer support is a crucial aspect of this, as it is a central characteristic of the 'Connectiveness' recovery process in the CHIME framework. Similar findings regarding peer support are also reflected in clinical populations (Braake, 2020).

Further to direct recovery intervention, this review also reports studies that applied personal recovery measures as secondary outcomes. Interventions consisted of teaching cognitive remediation skills (Ahmed et al., 2015), enrolment on employment schemes (Bond et al., 2015), and developing patient-clinician communication skills (MacInnes et al., 2016). All were found to be ineffective in changes to personal recovery.

It is theorised that these interventions are disconnected from the recovery paradigm, which may influence the results. Whilst communication skills and employment may align with 'connectedness' and 'meaning in life' respectively, it does not guarantee an alliance with recovery processes. For example, Bond et al. (2015) applied the IPS employment scheme. This scheme consists of eight principles, none of which map onto recovery models. Indeed, only one principle focuses on the client: 'attention to client preferences'. This finding may suggest recovery processes must be fully woven throughout an intervention to alter a measure of personal recovery.

Various associations were found between personal recovery and other constructs within in the current review. Aspects of personal recovery were found to have a negative effect on criminal thinking (Bartholomew et al., 2018) and a negative relationship with internalised stigma (Livingston et al., 2012), CJS involvement, psychiatric symptoms, and perceived coercion of the CJS (Pratt et al., 2013). Positive relationships between personal recovery and

personal empowerment and aspects of recovery-orientated care (Livingston et al., 2013) were also found. Of note, an unexpected finding of a positive relationship between a subscale of personal recovery, 'non-domination by symptoms', and engagement problems was reported (Sveinsdottir & Bond, 2017). These findings should be considered in the context of the quality appraisal, which found Sveinsdottir and Bond (2017) to be at moderate risk of bias.

The findings show some parallels with the CHIME framework, with 'Empowerment' being one of the five recovery processes and overcoming stigma as a characteristic of 'Identity'. Empowerment is also recognised within the recently developed model of recovery processes from a forensic service user experience (Lovell et al., 2020). Therefore, some relationships found in the current review are concurrent with wider literature.

However, it may be helpful to consider empowerment and stigma in greater detail for a forensic mental health setting. Whilst these are relevant to all individuals with severe mental illness, forensic psychiatric patients experience multiple stigmas, which could be an obstacle to recovery (West et al., 2014; West et al., 2018). Moreover, the relationship between empowerment and managing risk in this population is challenging (Pouncey & Lukens, 2010). Unique relationships with recovery processes found in the review warrant greater investigation and suggest a need to have additional aspects to recovery frameworks for a forensic mental health population.

The review also portrays minor conflict in results regarding the relationship between the provider's recovery competence and an individual's self-reported recovery. A positive association would be hypothesised. However, Livingston (2013) did not report this. Patient ratings of recovery-orientated care were not significantly correlated with personal recovery; only some subscales of measures were. The unexpected finding may be due to mediating factors in the relationship. Such has been found in clinical literature, including working alliance, information sharing, modelling, and choice (Moran et al., 2014; Winsper et al., 2020).

Whilst inappropriate application of the measure or study design can be considered, the study was considered at low risk of bias following quality appraisal for the cross-sectional design.

An unexpected finding in the review shows a positive relationship between ‘non-domination by symptoms’ and engagement problems (Sveinsdottir & Bond, 2017). This also does not appear to be conducive to the recovery model. It is of note that the study was rated as of moderate risk of bias. Consequently, the quality of the study could be one cause for the unexpected finding.

Overall, the majority of findings are as expected based on existing recovery frameworks. However, there may be additional stipulations that apply to a forensic mental health setting. Other psychological constructs unique to this population may be relevant to recovery and should be examined further. The tentative conclusions drawn from these studies suggest that a change to self-reported personal recovery is measurable. Though, it requires further exploration to develop appropriate interventions for this population and setting.

Are Current Personal Recovery Measures Appropriate in Forensic Mental Health Settings?

Of all published personal recovery measures, just four have had published use in a forensic mental health setting. Therefore, conclusions are drawn on these only. The RAS is the most frequently used measure, with superior psychometric properties, both in the current review and broader literature. Salzer and Brusilovskiy (2014) concluded the RAS had significant evidence to support its use as a measure of recovery, including evidence of good internal consistency, test-retest reliability, and inter-rater reliability. This review indicates the psychometric properties in a forensic mental health population, with good internal consistency of the RAS-41. However, the two studies which used the RAS-24 did not report psychometric properties.

In comparison, the three further measures found in this review reported various psychometric properties. The MHRM had reported adequate internal consistency in all the studies it was administered. The two studies which published the use of the QPR did not report internal consistency. Most notably, Jas and Wieling (2018) reported previous psychometric properties but did not investigate internal consistency for the specific study, despite making adaptations to the measure. The MARS was published in one study, which also did not report the Cronbach alpha. Insufficient reporting in the studies may reflect the quality of the study rather than poor psychometric properties of the measure itself. Consequently, a lack of reported internal consistency of over half of the measures in the review suggests further investigation is required.

Likewise, the quality of the papers may also impact the ability of the measures in demonstrating a change in recovery. Four of the studies failed to demonstrate significant results with personal recovery measures, and how recovery is measured is thought to impact the finding of significant results. Namely, that it is unsuccessful when used as a secondary measure. The review is also vulnerable to flawed analyses and reporting bias in some studies. Indeed, Livingston et al. (2013), Kopelovich et al. (2013), and Pratt et al. (2013) reported their studies to be underpowered due to inadequate sample sizes. Given the variation in the ability to capture statistically significant change, current personal recovery measures have demonstrated tentative suitability.

The review suggests scope for personal recovery measures to be appropriate in forensic mental health settings. However, how and why they are used should be greatly considered in the study design. The RAS-41 and MHRM may be most appropriate to be used in a forensic mental health setting, seemingly aligning with relevant theory and models whilst also demonstrating psychometric strength.

Recommendations

The review illustrates similar findings to those found in clinical settings; however, a tentative conclusion can be made due to a distinctly reduced literature base. Several recommendations are made which have implications for research and clinical application.

Research Implications

It would be most beneficial to build the literature in examining personal recovery in forensic mental health settings. This is two-fold. It would be advantageous to focus on one specific measure with an adequate existing literature base. The RAS appears to be the most appropriate choice, given its reported psychometric properties and fitting with the leading framework for recovery, CHIME. Additionally, the current review has found this to be the most frequently published within a forensic mental health setting at this time. Nevertheless, the literature would benefit from comparing all validated personal recovery measures in a clinical setting, in a forensic mental health setting. This would investigate which tool would have superior psychometric properties, sensitivity, and specificity specific to forensic mental health populations.

However, there is a need to greater develop a suitable framework for the forensic mental health population. The current review has established support for the CHIME framework; yet, it has also found potential additional psychological constructs that may be important to personal recovery in this setting. The development of new theoretical models, such as Lovell's (2020) work, has begun. However, these will need to be investigated further and with larger samples to draw supported conclusions. Once a framework has been established, it may be appropriate to examine these existing personal recovery measures against it. Alternatively, it may be that a more definitive and robust measure may need to be developed in line with the frameworks.

The field of literature may also benefit from research examining specific aspects of the recovery model as areas of intervention. The current review indicates interventions are successful in increasing self-reported personal recovery when targeting a specific model element, as highlighted in successful interventions that align with 'connectiveness' rather than all facets of recovery (Compton et al., 2016; Livingston et al., 2013). It may be helpful to consider if one factor can influence the construct as a whole. While building the literature base in a forensic mental health setting, it is advisable to compare how interventions address recovery and the efficacy of this. Research should explore if interventions are most successful when addressing all areas of personal recovery or its specific aspects, including 'connectiveness', 'hope and optimism about the future', 'identity', 'meaning in life', or 'empowerment' interventions. Moreover, if successful interventions target specific areas, it may also be an area of interest to explore outcome measures specific to the aspect of the recovery the intervention is addressing. This may be one method to increase the sensitivity and reliability of measures to demonstrate a change in personal recovery.

Clinical Implications

The application of a personal recovery outcome measure in forensic mental health settings should be considered with caution. However, the measures have shown to be used successfully with appropriate study design and can add value. Based on the review findings, it is recommended that it may be inappropriate to measure personal recovery as a secondary measure or if there is no direct intervention to address personal recovery. It may be that indirect interventions do not impact personal recovery, or the existing measures are inappropriate to capture any change in this context. Therefore, which factors specifically change personal recovery require significant consideration. Although few studies investigated direct

interventions to increase personal recovery, the results show that this can be conducted within a forensic mental health setting. The use of peer support may be a crucial aspect of this.

Strengths and Limitations

A thorough systematic technique has been applied and adhered to, including a quality appraisal of the studies, to summarise the existing literature and produce reliable and accurate conclusions. This systematic review is, therefore, an original contribution to research. A further strength lies in the review's ability to synthesise the literature to create a direction forward for this field.

The review focused on which measures were applied and how, with deductions made from this. The review did not compare measures to a conceptual framework. This decision was most appropriate given the lack of support for a specific framework in forensic mental health settings. However, a future review examining this would be beneficial. This highlights a significant limitation to the literature review, in that a universally accepted definition of personal recovery in forensic mental health settings remains to be established. The use of different measures in this review could reflect different operationalisations of the concept in each study which may impact the ability to compare findings and draw inferences. A further limitation is the heterogeneity of the studies included in the review, including differences in study setting, design, risk of bias, and intervention effects, which may impact the applicability of the findings. However, this is a reflection of the limited number of published studies.

Conclusion

The study of personal recovery remains scant within forensic mental health settings despite being identified as vital in mental health research, policy, and practice. The current review was designed to identify the current state of research and provide a direction for future

work. Specifically, to identify and critically review the use of measures of personal recovery in forensic mental health settings. A systematic search of three databases found 11 papers identifying the use of four measures of personal recovery in a forensic mental health population. The measures have been used to assess intervention and examine relationships between constructs, with parallels to existing frameworks of personal recovery found. However, the results should be interpreted with caution due to the limited breadth of the literature.

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EMPIRICAL PAPER

STAFF PERCEPTION OF PERSONAL RESPONSIBILITY IN FORENSIC MENTAL
HEALTH SERVICES: A THEMATIC ANALYSIS

Abstract

Background

The construct of personal responsibility is cited across multiple fields of literature, holding a central role in the mental health recovery paradigm (Andresen et al., 2003; Leamy et al., 2011) and offender rehabilitation models (McGrath et al., 2009; Ward et al., 2014). Despite its frequency in research, what it is and how to address it in a rehabilitative context remains unexplored within forensic mental health. Yet, other research fields have begun to evidence its identity as distinct and its applicability (Mergler & Shield, 2016). Gaining insight into how personal responsibility is understood and integrated into this setting examines the gap between the frequency in literature and practice.

Method

Reflexive Thematic Analysis was used to analyse semi-structured interviews conducted with 11 clinicians within a forensic mental health setting. A focus group with six service users was facilitated as a form of data triangulation to strengthen the credibility of the analysis.

Results

The analysis identified three main themes and a further seven subthemes which captured participants' understanding and application of the term in forensic mental health. The themes relate to a lack of confidence in understanding the construct, the processes required to build a service users' personal responsibility, and the dynamics between secure mental health services and service users.

Conclusion

The study offers novel insights into the complexity of personal responsibility in this setting and has drawn links to different paradigms within published literature. It, therefore, has furthered the theoretical understanding of the construct. Clinical practice and future research implications are also provided.

Introduction

This paper explores the construct of personal responsibility in a forensic mental health setting. A review of the literature suggests the concept heavily features in models of mental health recovery and offender rehabilitation. However, it presents a paradoxical term in forensic mental health, given potential conflicting positions held by service users and clinicians (Lakeman, 2016). To date, there is no clear sense of how personal responsibility is understood, considered, and facilitated in forensic mental health settings, given the potential conflicts and different agendas required.

Defining Personal Responsibility

There have been many discrepancies in defining the term ‘personal responsibility’. It has been examined from multiple perspectives and contexts, evidencing shifts in understanding, from viewing it as an individual trait, an attribute of a person or situation, a motive, an attitude, or social value (Auhagen & Bierhoff, 2002). Yet, the move away from defining personal responsibility as a unidimensional construct, or a stable personality characteristic (Winter, 1992), has been significant to its development. Research suggests that personal responsibility is likely to be multi-relational, operating alongside additional constructs such as effort, locus of control, and self-efficacy (Auhagen & Bierhoff, 2002; Weiner, 1995).

Lauermaann and Karabenick (2011) have constructed a helpful definition of personal responsibility within the field of educational psychology as “a sense of internal obligation and commitment to produce or prevent designated outcomes, or that these outcomes should have been produced or prevented” (p127). This definition draws on Weiner’s work (1995) by identifying a ‘should’ element in its definition. Personal responsibility and related constructs may share the element of causality, yet responsibility differs due to the inclusion of ‘what

should be,' e.g., 'I should try hard.' This theory contrasts with the construct of locus of control, e.g., 'something happened because of me versus something should have happened because of me' and self-efficacy 'I can versus I should' (Lauermann & Karabenick, 2011b). The authors further argue that personal characteristics and contextual factors are important elements but not fixed determinants of personal responsibility (Lauermann & Karabenick, 2011).

Most notable within educational psychology is a range of outcome measures created to capture change in personal responsibility quantitatively. Please see Appendix A for a list of measures. This table further highlights the disparity in an agreement on which factors, and how many factors, underly the construct; ranging from one factor of personal responsibility alone to four factors consisting of 'initiative,' 'self-efficacy,' 'control,' and 'motivation' (Singg & Ader, 2001; Stockdale & Brockett, 2011). A prominent measure is the Personal Responsibility Scale (Mergler & Shield, 2016), which established personal responsibility to be a multidimensional construct that includes behavioural, cognitive, and emotional and moral components. The measure has demonstrated adequate psychometric properties (Malinauskas, 2019; Mergler & Shield, 2016), contributing to evidencing the construct's identity as distinct from similar constructs while also highlighting possible research to examine potential manipulation of personal responsibility.

Personal Responsibility's Integration in the Literature

Personal Responsibility and Recovery

Personal responsibility forms a central pillar in models of recovery, with syntheses of the literature finding vital components to be hope, identity, meaning, and personal responsibility (Andresen et al., 2003; Ralph, 2000). As the recovery literature developed, the CHIME framework was established and identified to be the most widely endorsed and valid

(Leamy et al., 2011; Slade et al., 2012; van Weeghel et al., 2019). The construct of personal responsibility sits within this as a second-order subtheme of 'Empowerment'. It is clear that personal responsibility holds a role in mental health recovery, with a focus on the individual being accountable for their care; "personal responsibility for their own self-care and journeys of recovery" (Slade et al., 2008, p. 130). The CHIME model outlines the recovery process and suggests guidance for intervention, from the individual to the organisation. Indeed, Slade and Hayward (2007) identified future directions for the recovery movement to include developing pro-recovery interventions such as promoting personal responsibility for the service user.

The move towards applying a recovery model in forensic settings has also gathered speed, with forensic psychiatry tasked with encouraging patient choice, responsibility, and self-determination while opposing coercive treatment (Pouncey & Lukens, 2010). Recovery in a forensic setting aims to "increase service users' ability to explore and develop an understanding of their experiences but would also enable them to begin to take some personal responsibility for their recovery" (Drennan & Alred, 2013, p. 134). However, clinical models of recovery have evoked conflict in such a setting, due to the existence of differences. Research suggests elements of choice, recovery, hope, responsibility, agency, and risk are critical components in a forensic recovery model (Gulayets & Sawyer, 2020), suggesting additional aspects to recovery in forensic mental health settings. Namely, the battle of managing risk and recovery, the inclusion of personal responsibility remains evident.

Personal Responsibility and Offender Rehabilitation

Personal responsibility is also a long-standing construct applied throughout various offender rehabilitation models, with Salter (1988, p. 175) stating that "a primary goal of any treatment programme is to enable offenders to take responsibility for their behaviour". How

the construct is applied, however, has proven to be more be divisive. Traditional offender behaviour programmes, including those addressing needs from interpersonal violence, sexual offending, and substance misuse, imply a requirement for the individual to take responsibility for the offending behaviour itself (De Leon, 1989; Gallagher, 2014; McGrath et al., 2009; Palmer, 2006). Certainly, evidence suggests that 91% of inpatient and community-based programs for adult offenders in the United States include “offender responsibility” regarding the act (McGrath et al., 2009). It is argued that this acceptance of responsibility allows individuals who have offended to “create a sense of agency and shift in narrative identity” (Ward et al., 2014, p. 35), with some suggesting the approach as appealing to the offenders’ free will and empowering them to act differently (Robinson & Crow, 2009).

Conversely, there has also been an argument for shifting away from acknowledging responsibility for the offence. Research has called for responsibility not to be emphasised for past behaviour, but future actions (Maruna & Mann, 2006; Ware & Mann, 2012). This aligns with recovery principles and does not detract from the role of personal responsibility in offender rehabilitation. It also appears to align with the development of the Good Lives Model (GLM) (Ward & Brown, 2004) and Therapeutic Communities (TCs) (Pearce et al., 2017) as alternatives to mainstream offender rehabilitation models. These strength-based approaches to offender rehabilitation have both placed importance on the role of personal responsibility (Freestone et al., 2014). The GLM works with individuals towards achieving ‘primary goods’ with a particular focus on personal identity and psychological wellbeing (Ward et al., 2007). One of the 11 primary goods, ‘excellence in agency’, encompasses personal responsibility. Likewise, personal responsibility was stated as a “hallmark” within TCs (Ware et al., 2010), with a good fit between the GLM and TCs identified (Brookes, 2010). TCs are relationship-based treatment environments where all social interactions and activities focus on therapeutic goals combined with group therapy. TCs explicitly aim to

promote ‘independence and self-responsibility’ to move towards personal growth (Day & Doyle, 2010). Therefore, the application of personal responsibility is substantial.

Research has also accounted for a relationship between personal responsibility and treatment engagement and attrition. Published studies evidence acceptance of personal responsibility as a component for readiness for offender treatment (Casey et al., 2007), an element of motivation for treatment engagement (Barrett et al., 2003), and an imperative factor in remaining in treatment (Pettersen et al., 2014). Furthermore, a significant correlation was found between higher acceptance of responsibility following treatment and successful reoffending outcomes (Barrett et al., 2003). Of note, responsibility in this field of research was captured through qualitative approaches or the use of measures that were not specific to personal responsibility, such as the Goal Attainment Scaling system (Hogue, 1994). There is no published measure of personal responsibility for this population or setting.

As outlined, personal responsibility in offender rehabilitation appears to take many forms. Evidence suggests it may be a requirement before treatment and be a treatment outcome in itself. Furthermore, how the construct is defined and worked towards also depends on the models’ approach.

Rationale

Personal responsibility has a strong presence in the theoretical background of mental health recovery and offender treatment models. Research also suggests it may be a requirement before treatment as well as a treatment outcome in itself (McGrath et al., 2009; Ware & Mann, 2012). Despite its frequency in research, what it is and how to include it in a rehabilitative context remains unexplored. There continues to be a lack of clear understanding of the construct. Nonetheless, other fields of research have begun to evidence its identity as distinct and applicable (Mergler & Shield, 2016).

The current study looks at the construct of personal responsibility within a forensic mental health service. Forensic mental health services are unique settings where mental health recovery and offender treatment are each principal treatment aims and therefore may face particular difficulty to establish the role of personal responsibility. This narrative study aims to understand the construct of personal responsibility for forensic mental health service users. Staff perspectives are sought to achieve this, as clinicians have been noted to be central in the application of recovery principles, since they connect policy and practice (Hardiman & Hodges, 2008). Gaining insight into how personal responsibility is understood and integrated into this setting establishes the bridge from the reference in literature to current practice. This will address the identified gap in the evidence base and could help to further the theoretical understanding of the construct.

Research Questions

1. How is the personal responsibility of a service user in forensic mental health services understood?
2. How is the construct integrated into forensic mental health services?

Methodology

The methodology for the study significantly changed while it was conducted. Please see Appendix B for full details and reflections on the process.

Design

A qualitative design was used to answer the research questions. Semi-structured interviews were conducted with staff members within a forensic mental health setting, and a focus group was facilitated with service users of the same setting. The interviews were

transcribed verbatim by the researcher and analysed using Reflexive Thematic Analysis (Reflexive TA) (Braun and Clarke, 2006; 2019). The focus group data was used as a form of triangulation; this is the use of multiple methods or data sources to further develop a comprehensive understanding of phenomena (Patton, 1999). Data triangulation using focus groups and interviews has been found to result in a broader understanding of the phenomenon of interest (Carter et al., 2014).

Recruitment Sites

All participants were recruited from a medium secure service within a psychiatric hospital. The medium secure division consisted of five wards, with both staff and service user participants recruited from four of these. The ward excluded from recruitment manages deaf or hearing-impaired patients with complex mental illness, thus was excluded from due to barriers to engage and potentially significant cultural differences.

Participants

Service User

The inclusion criteria for the service user participant group were for participants to be aged 18 years or over, had the capacity to provide informed consent, and able to engage in a focus group facilitated in the English language. Eleven participants who met the inclusion criteria were identified in the service. Six individuals consented and participated in the focus group. Demographic information is presented in the table below.

Table 1. Service User Participant Demographics

Participant	Gender	Age (years)	Diagnosis
1	Male	22	Mixed and other personality disorders
2	Male	54	Unspecified nonorganic psychosis Post-Traumatic Stress Disorder Emotionally unstable personality disorder
3	Male	24	Schizoaffective disorder Emotionally unstable personality disorder
4	Male	65	Mild cognitive disorder Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures
5	Male	40	Emotionally unstable personality disorder Diffuse brain injury
6	Male	23	Organic Hallucinosiis

Staff

The inclusion criteria for the staff participant group were to have a service user-facing role (a qualified or unqualified position) and to have worked in the service for a minimum of a year. A requirement for the length of time in the service was stipulated as it was considered vital that participants had an appropriate experience of working in the service to provide adequate data. A total of twelve participants expressed an interest in participating, eleven of which completed and gave consent for the interviews to be recorded. Demographic information is presented in the table below. All eleven transcripts were included in the data analysis.

Table 2. Staff Participant Demographics

Participant	Gender	Discipline
1	Male	Psychology
2	Female	Nursing
3	Female	Psychology

4	Male	Nursing
5	Female	Occupational Therapy
6	Female	Occupational Therapy
7	Female	Nursing
8	Female	Occupational Therapy
9	Male	Psychology
10	Female	Psychology
11	Female	Occupational Therapy

Interview Schedule

The researcher created a semi-structured interview schedule (Appendix C) and focus group questions (Appendix D). These were based on relevant literature, including exploring the paradoxes of personal responsibility, and previous qualitative research into the construct (Lakeman, 2016; Mergler & Patton, 2007). A local collaborator (Consultant Clinical Psychologist) was consulted during the process.

Ethical Approval

Ethical approval was sought and granted from the University of Birmingham's Ethical Review (Appendix E) and the Research and Development Team for the hospital in which the research was conducted (Appendix F).

Procedure

Service User Focus Group

Potential participants were identified through local collaborators. The local collaborators screened potential participants in the service to establish who would be eligible to meet the inclusion criteria. If deemed to be eligible, they were offered a Participant Information Sheet (PIS) (Appendix G). The researcher then approached potential participants if they expressed an interest in participating and were given an opportunity to review the PIS, with opportunity to ask questions, before the Consent Form was completed (Appendix H). They were also provided with a slip containing details for the focus group. The focus group was facilitated on site and ran for approximately one hour in length. The focus group data was gathered by the facilitator recording themes on a flip chart paper and the local collaborator typed notes on a laptop. The notes included a sense of what group members said, how these were said, and quotes. Participants were also invited to write down their thoughts on paper provided. The data collection method was chosen due to hypothesised recruitment difficulties, as guided by a local collaborator, if a Dictaphone was used.

Staff Interviews

Participants were informed of the study by email, which contained a flyer in the email body (Appendix I) and the PIS attached (Appendix J). The suitability of participants who expressed interest in the study was determined through email, and consent was gained through the completion of an electronic consent form (Appendix K). Interviews were facilitated over the phone or Microsoft Teams and were recorded using an encrypted Dictaphone. These were transcribed verbatim by the researcher who conducted the interviews. Interviews ranged from 50 to 80 minutes in length.

Data Analysis

Reflexive Thematic Analysis

Reflexive TA, the result of further development and clarification of Braun and Clarke's (2006) TA, illustrates the researcher's subjectivity as an analytic resource within the TA process. This approach was chosen as Braun and Clarke (2019) outline its use to examine factors that influence, underpin, or contextualize a phenomenon; therefore, it was deemed appropriate to answer the proposed research questions. Reflexive TA has been applied deductively to this research as existing theory has provided a lens through which the data was analysed and interpreted. For example, codes and their interpretation were informed by the theoretical understanding of recovery models and educational psychology research on the construct (Leamy et al., 2011; Mergler & Shield, 2016; Swaner, 2005). However, there were no predetermined concepts held for the codes or themes. The research aimed to explore meaning at a semantic level, examining the explicit meaning of the data.

Theoretical Position

A researcher's theoretical position details the set of assumptions they hold of reality which informs how research is analysed and interpreted, examined through reflexivity. Understanding the relationship between a researcher's ontological, epistemological, and methodological assumptions that underpin their research is beneficial (Waring, 2012). Thus, to enhance reflexivity in the research, a positioning statement was devised (Appendix L). A reflective research journal was also maintained through the data collection and analysing process to capture reactions, interpretations, and reflections.

Analytic Process

The transcripts were analysed following the six-phase process outlined by Braun and Clark (2006; Braun et al., 2019). The process began with familiarisation with the data, followed by coding. Guidance for reflexive TA state coding is an organic process for which no coding framework is used (Braun & Clarke, 2020). Coding was completed line-by-line for each transcript, identifying any significant features of the data relevant to the research questions. Codes were collated and examined to begin the development of themes. Initial themes were generated, then reviewed against the dataset before being defined and named. The three phases for developing themes were to ensure each theme appropriately demonstrated a pattern of shared meaning, underpinned by a central concept within the data. These were then understood within an analytic narrative using supporting data extracts.

Credibility of Analysis

Measures, guided by Yardley (2008), were taken to ensure the credibility of the data. Once the data was transcribed and anonymised, the research attended qualitative workshops. The aim of attendance was not to determine inter-rater reliability, as this is inconsistent with the reflexive TA approach. These were used to reflect on the coding process, including discussions of assumptions held, to highlight required clarification of codes and coherence of thought through the analysis.

Triangulation was also applied within the analysis through the use of the focus group data to ensure credibility. The focus group data was organised into domain summaries; these are summaries of participant responses concerning a particular topic. This approach was chosen because coding and the generation of themes were not appropriate for the type of data

collected. Triangulation was conducted by comparing domain summaries from the focus group to the codes generated from the interviews. Additional codes on any agreement and disagreement between service users and staff were generated.

Results

The thematic analysis process was applied, which elicited three central organising concepts in the data. From this, three themes were developed and labelled as ‘I actually do not have a very clear idea’, ‘Building blocks’, and ‘Personal responsibility is not located in the individual’. Seven sub-themes also became apparent. These are represented in Figure 1.

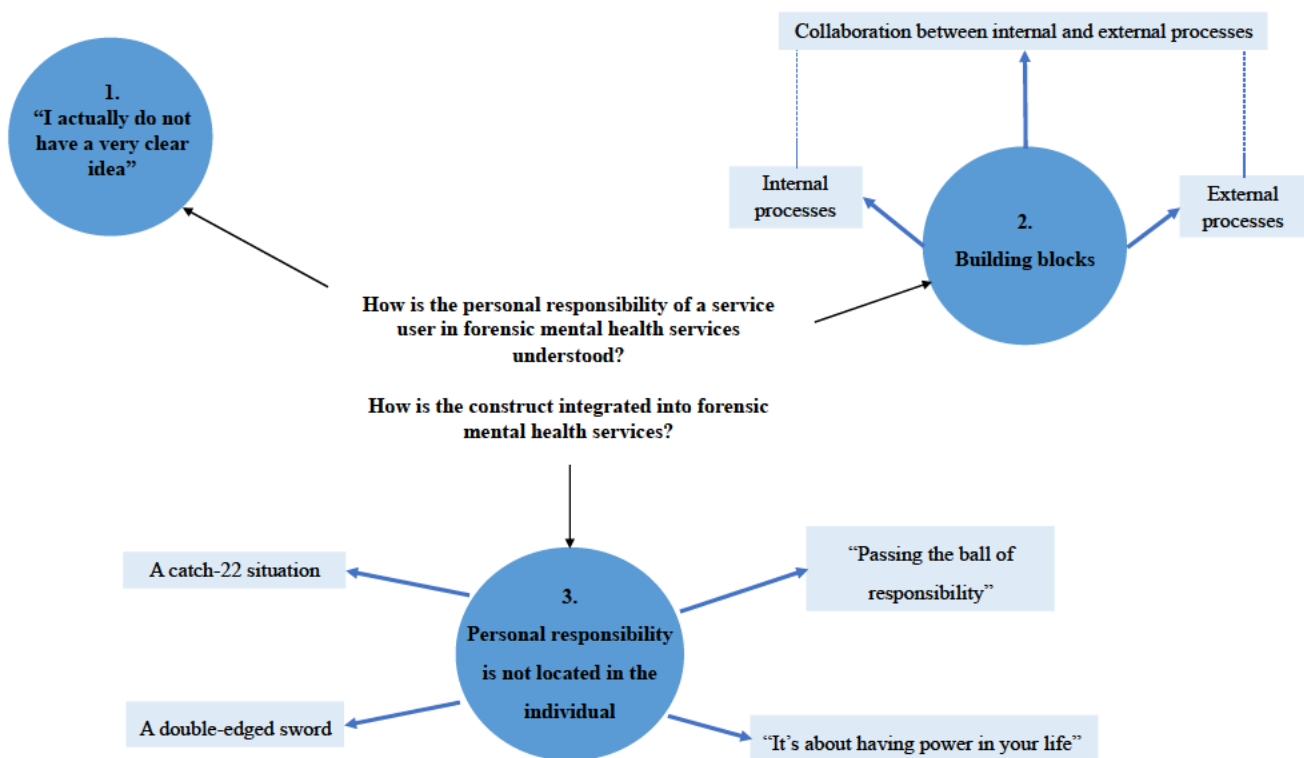


Figure 1. The three themes and seven subthemes from the data.

An overall narrative was one of clinician’s attempting to navigate a pathway to building personal responsibility in forensic mental health services. Participants attempted to

understand the construct before outlining the elements required to influence it, forming the first two themes in the study. The findings can be understood as participants 'setting a route' by attempting to comprehend the construct's boundaries, captured in the theme 'I actually do not have a very clear idea'. Participants then described the processes involved in influencing the construct, which suggests the journey, captured in the theme 'Building blocks'. The third theme centres around personal responsibility being dependent on the service, not the individual. The final theme captures the participant's perception of who is in the driving seat for this journey. These ideas are discussed below.

Theme 1: "I actually do not have a very clear idea."

This theme captures the reoccurring pattern identified across the dataset of a lack of understanding participants held for the construct. There was much data on how participants had previously had little consideration of the term and the difficulties the participants felt in defining personal responsibility, as captured by P6.

P6: "It's strange because I just want to use the word responsibility and you would say it's about taking responsibility for yourself that's a very concrete way of describing it but actually when you think about what responsibility looks like or feels like or how that manifests in itself and their behaviour then it gets really complex and then how do you describe it" (Pg. 3, L57-63)

Throughout the interview, participants were able to create some boundaries of what would, and would not, be considered as part of the construct of personal responsibility. However, there remained elements of guesswork, and it appeared effortful for participants to

do so. P3 and P9 illustrate participants reporting the components and structure with uncertainty.

P3: *“Ok I’m thinking in terms of responsibility I guess it’s erm it’s taking ownership of yourself of your behaviour your beliefs your attitudes sort of its quite hard to describe isn’t it responsibility” (Pg.1, L8-10)*

P9: *“that’s kind of the levels of responsibility and it all starts with actually being responsible for yourself and your actions in in a less stimulus area with less demands made upon you and that you take greater and greater levels of responsibility can you separate that into I don’t know in my head- it’s in my head” (Pg. 12, L266-269)*

Specific components of personal responsibility were regularly reported first and most frequently. These were the existence of a behavioural component and that the construct existed as a graded structure. The graded nature refers to participants’ understanding that there would be greater or lesser degrees of personal responsibility as summarised by P5.

P5: *“it’s almost like a hierarchy like when you think about Maslow’s hierarchy of needs... you’d expect a greater awareness and a greater ability to use personal responsibility as you went up the hierarchy until you know you’ve mastered it” (Pg. 12, L216-2190)*

Participants identified further components to the construct as they elaborated on their thoughts. When seeking to make sense of the component-related data, existing relevant literature was used to ground the data in a form of deductive coding. The components supported by current data were ‘behavioural’, ‘cognitive’, ‘emotional’, and ‘moral’ elements. These were understood within the theoretical understanding provided by educational psychology research (Mergler & Patton, 2007;

Mergler & Shield, 2016; Swaner, 2005). From the data, the four components were considered to be elements of the larger whole of personal responsibility. A 'behavioural' component was most frequently cited, with a service user's behaviour to be a marker of personal responsibility, expressed by P5 and P9.

P5; *"how you act and behave... behaviours or actions are concurrent or incongruent with responsibilities"* (Pg. 1, L9-16)

P9: *"there's also the actions and the doing part of it where actually it's what you how you present yourself to others"* (Pg. 2, L43-44)

The cognitive component captured the requirement of service users to understand the process of taking personal responsibility in order to do so. It also highlighted the involvement of the executive functioning as well as the consideration of taking responsibility for thoughts. P9 and P6 comment on this.

P9: *"I suppose responsibility is also a cognitive awareness"* (, Pg. 12, L285)

P6: *"you need to have erm a lot of insight into your strengths and areas to work on to then be able to understand what action you have to take"* (Pg. 1, L10-11)

An emotional component sought to make sense of participants reporting how an awareness of, and ability to manage, emotions would be required as part of personal responsibility. P1 and P8 state this.

P1: *"ultimately we have personal responsibility for how we manage our emotions"*
(Pg. 7, L167-168)

P8: *“having responsibility of knowing of having an awareness of your emotions and how they and how you erm respond with them”* (Pg. 1, L4-6)

The final component was a ‘moral’ element. This encompasses the relationship between personal responsibility and an individuals’ moral and values. Commonalities between participants highlighted that personal responsibility was developed by a moral awareness, and that in order to appropriately take personal responsibility, the individual would be acting in line with their particular set of morals. P11 and P7 describe the role of moral through actions and the construct’s development.

P11: *“telling staff... you know that comes into their responsibility you know of speaking up and saying what’s right and what’s wrong”* (Pg. 13, L297-300)

P7: *“I think it’s learnt to be fair with you erm it’s through conscience and things isn’t it”* (Pg. 14, L326)

Patterns in the data connected the lack of understanding to the context's complexity and how the population differs from the general public. Participants suggested that whilst the definition would be considered the same to other contexts or populations, differences would need to be considered. P1, P10, and P6 describe difference in forensic mental health service users in several different ways.

P1: *“I would think the personal responsibility would be the same it may be that the ordinary population probably erm have may have less need to think about their responsibility around certain areas... I think there’s probably a difference that may actually make it then much more complex”* (Pg. 3, L60-66)

P10: *“if you were seeing somebody in the community with er psychological deficits in some way and they’re coming choosing to come and see you that’s purely because they want to er empower move- improve themselves in some way psychologically it’s not like here”* (Pg. 9, L206-209)

P6: *“I think the definition would be the same and the understanding would be the same but the level of being able to accept personal responsibility would be very different”* (Pg. 2, L31-33)

The difference in forensic mental health settings can also be seen through avoidance of discussing personal responsibility or choosing an alternative language in this setting. Participants cited this was due to the context which combines forensic and mental health needs. The lack of use, or discussions around the construct, can also be considered linked to a lack of understanding. P4 and P8 discussed the absence of the construct in the setting and how they had not considered this previously. This encapsulates the absence of understanding as participants were not previously aware of their lack of use or underdeveloped knowledge before the interview.

P4: *“I don’t know it feels like I use the word responsibility at home but at work I feel like it’s a bit of a finger pointy word so I don’t talk about responsibility... a lot of what we do is even if indirectly based around getting people to take responsibility for themselves but I don’t I don’t think I use the word responsibility which I have never thought about”* (Pg. 15, L293-338)

P8: *“I think it probably goes kinda unspoken stroke mentioned in passing... actually I’ve not actually really thought about it [laugh] if it’s been said before actually”* (Pg. 14, L307-314)

Theme 2: Building blocks

This theme summarises participants identifying key elements required to be present or implemented to build the personal responsibility of a service user. Data highlighted three elements, firstly those that exist in the individual. Secondly, those that highlight how the environment around an individual, such as the service or professionals, should approach building responsibility. Finally, data highlighted how collaboration between the first two processes is vital in developing personal responsibility. Thus, the patterns in the data were divided into three subthemes to explore specific elements of the underlying concept.

Internal processes

‘Internal processes’ obtains essential elements held by the service user required in increasing personal responsibility. ‘Self-concept’ constructs of self-efficacy and self-esteem were noted to be intertwined with personal responsibility. Participants spoke of how these, and related constructs of effort and motivation, were influential on the construct. Notably, positive correlations were described in that high levels of one construct would imply high levels of the other, and as one increased, so would the other. These were not defined as prerequisites for personal responsibility but require consideration and potentially alter the best approach to working with the individual to build personal responsibility. P9 describes the perceived relationship between self-esteem and personal responsibility. Whereas P6 and P7 describe the relationship personal responsibility has with effort and motivation, respectively.

P9: “for some people especially people with very low self-esteem very low self-worth you’re not going to be able you’re not going to wanting them to have experiences that don’t that have any errors in them because it will just knock them and their view of

themselves erm and their self-esteem so they may actually then neglect their own personal responsibilities to themselves” (Pg. 17, L387-391)

“ultimately if you don’t see yourself as a person of worth what’s the point of being responsible you know it’s irrelevant really” (Pg. 27, L620-622)

P6: *“effort is a huge huge subject in itself but you need to put effort into personal responsibility erm and our patients can’t sustain effort they can put effort into short periods or bursts and then that effort wanes they can’t sustain it so if you want to be personally responsible but you can’t maintain that effort to put into that then then you’re not going to be personally responsible” (Pg. 7, L152-156)*

P7: *“we can tell them about them and but you can’t make people do things that are not there in the beginning... It’s got to be something that they want even just a little tiny bit” (Pg. 16-17, L379-391)*

Personal responsibility appears to align as a 'self' construct in that it was frequently cited as being tied to identity. With this, participants also stated the need for personal responsibility to be made meaningful to the individual. An individual would need to take responsibility in areas that resonate with them, further linking with motivation again. P8 can be seen describing the interconnectedness of motivation, meaningful activity, and building personal responsibility.

P8: *“you can actually look into what is it’s that motivates that person what can capture that person’s interest and say ok you really like spending time out in the courtyard how about it’s your responsibility to erm make sure there’s nothing to trip over... it works you know it’s just finding that thing that kind of gets the spark and then you build on that” (Pg. 9, L205-210)*

The ethos of this subtheme is also evident within data that highlights the process of building personal responsibility as requiring an internal shift for the individual. Participants reported behavioural change was not enough to be considered a change in personal responsibility, but the change also required internalisation of the construct. This can be seen as concurrence with the first theme, in that several components make up personal responsibility. P5 emphasises the link with identity and how this differs from a behavioural aspect of personal responsibility. Whilst P10 discusses a process of internalising for a service user that occurs when taking personal responsibility.

P5: “they’re very kind of connected to your core being or your identity... I think you have to kind of put roles and responsibilities together and kind of group them into different levels almost of where you might see overt behaviour and where you might kind of it might be getting more entwined with identity” (Pg. 1-2, L22-28)

P10: “there’s a sense of he’s actually taking on that level of personal responsibility himself he doesn’t need that external thing to show that its almost making the external internal” (Pg. 14 309-310)

External processes

Participants identified elements from the environment around an individual which are required in building personal responsibility. Participants noted external management strategies would impact an individual's level of personal responsibility and frequently referenced the supporting role professionals had in aiding personal responsibility. P3 discusses how this is sustained through a multidisciplinary approach.

P3: *“they may have a lot of other factors that are preventing them from you know having taking that responsibility so as clinicians we need to support that more to start with... that takes a lot of effort not just from psychologists from nurses from everybody”* (Pg. 13-14, L298- 324)

Support for this subtheme relates to further patterns found in the data observing the need for opportunities to be made available to individuals to trial responsibility, including positive risk-taking and being given a chance to fail. These were considered to be the role of the service. P2 and P11 highlight opportunities that would need to be required.

P2: *“actually allowing people to make slightly unwise choices is part of them taking responsibility for what they’re doing”* (Pg. 13, L306-307)

P11: *“I suppose it is a little bit of positive risk taking and trying to be least restrictive where you can while managing the risks I think that just builds on you know a kind of accountability and independence which I think yeah I think all helps with with feeling personally responsible”* (Pg. 11-12, L262-265)

Also captured in this subtheme is a process of externalising behaviours, making the implicit explicit. Participants described a need for tangible explicit explanations to be provided to service users. Similarly, the pattern of making the implicit explicit is captured in the requirement for outward change. Participants discussed the need for any changes made by service users to be demonstrated through behaviour. Extracts from P6 state a need to make expectations explicit as part of the facilitating process, and in turn, P7 states the need for service users to show explicit behavioural change.

P6: *“lack of understanding will would have a huge impact on being able to take personal responsibility but as a therapist if I’m going to facilitate somebody taking personal responsibility I have to make those expectations explicit”* (Pg. 9, L189-191)

P7: *“their actions need to speak louder than perhaps words a very old saying but.... they have to show that that’s what they do”* (Pg. 23, L536-542)

Collaboration between internal and external processes

Through identifying internal and external processes, participants also detailed how these would need to be considered together. A prominent pattern in the data showed personal responsibility is taken within interpersonal interactions and grounded in society. The role of interpersonal interactions was understood as personal responsibility being only available to an individual if there is an other involved. P5 summarizes the ployout between internal and external processes as developing the construct.

P5: *“I think personal responsibility is developed by that play out between you know a society or people or your network and your environment”* (Pg. 15, L355-357)

The nature of secure mental health services was also suggested to be influential on why there needed to be a collaboration between the internal and external processes. P8 describes how the two aspects would need to be combined due to the specific nature of the setting and service users.

P8: *“which is a collaborative thing to begin with certainty it would have to be that way one because of the setting we are in but secondly because of the service users and what they need”* (Pg. 15, L364-365)

A collaboration between the previous two subthemes also highlighted a need for the internal and external processes to be appropriately attuned to each other. Any external processes, such as support from the environment, needed to be in line with the individual's ability at that time. Attunement is also reflected in participants discussing the appropriateness of teaching and learning personal responsibility. P4 captures the consequences of failing to meet the individual at the appropriate level. Then, P3 discusses the need to teach personal responsibility in line with the service user's prior knowledge, experience and skills.

P4: "getting the level right you don't want people to think you're babying them or to think they're stupid and you're over doing stuff for them but you also don't want them to feel like they're just really isolated and no one can be bothered to help them either"
(Pg. 16, L370-373)

P3: "sometimes they physically don't have the knowledge or you know the experience or the skills so you have you're having to teach them how to take responsibility" (Pg. 20, L487-489)

Theme 3: Personal responsibility is not located in the individual

The theme 'Personal responsibility is not located in the individual' captures a dynamic between secure mental health services and service users. Despite the construct including the word personal, participants recognised services held a sense of control over an individual's personal responsibility, neatly captured by P6.

P6: "control is involved isn't it? How much control are we going to give" (Pg. 19, L472-473)

Participants understood the construct to be vulnerable to many different factors specific to a forensic mental health context, captured in the subthemes.

“It’s about having power in your life”

Participants discussed the relationship personal responsibility had with power and how the context of forensic mental health services influenced the position held by the service user between two possible extremes: empowerment and disempowerment. The construct was seen as being associated with empowerment, which also connected with codes highlighting personal responsibility's relationship with a sense of control and choice. P2 describes the closely tied relationship between power and choice.

P2: *“personal responsibility is a lot to do with power... it’s about having power in your life isn’t it if you’re taking responsibility if you’re like me and taking responsibility for everything then that’s given me a feeling of power in my life”* (Pg. 11, L249-252)

“I think erm if we were to give people more choices that would be a start... you make an allowance that they will take responsibility for things like giving them a choice” (Pg. 12, L282-286)

However, participants strongly acknowledged that the service often held power. When responsibilities are enforced on an individual or the power was not appropriately shared, the concept was found to disempower service users. P1 captures this by describing how procedures within service limit choices and disempower service users.

P1: *“although a lot of things that we often do are quite er disempowering and very easily make people dependent... yes people should be taking personal responsibly but then we undermine it by not allowing them to make choice”* (Pg. 12, L273-282)

“Passing the ball of responsibility”

Accountability repeatedly featured in the data. Firstly, it was considered concerning consequences and that these served to establish personal responsibility by holding an individual accountable for the consequences of their actions. Yet, participants also identified service users were unable to hold full accountability. Accountability was found to also be held by professionals and further impacted by factors such as mental health difficulties. Participants expressed conflicting views and uncertainty in how accountability should be understood in relation to personal responsibility in this setting, as reported by P5 and P10 through examples of assault.

P5: *“I don’t think we’re quite there yet around patients taking responsibility for what they might do erm I know that there’s a real divide with staff as well in terms of you know convictions when in hospital because there’s this idea of someone being unwell and perhaps not being able to manage their behaviour but also the need to take responsibility for the fact they might have seriously harmed someone and that there should be a consequence to that”* (Pg. 18, L407-412)

P10: *“if I really help them release too soon and they go on hurt somebody in the community I’m responsible for that aren’t I?”* (Pg. 27, L611-613)

With this, participants discussed how accountability sat with the professionals and organisation. Thus, in order to build personal responsibility, a collaborative process would be

needed. A common pattern capturing this is how a service user's level of personal responsibility would increase and decrease at times, impacting the extent to which professionals were accountable for the service users' responsibility. Accountability was seen as fluid throughout someone's recovery, as reported by P6 and P11.

P6: *“the responsibility lies wholly on the healthcare professionals but then as someone as a patient gradually gets better and that mental illness improves then that responsibility can then gradually grow”* (P6, 563-565)

P11: *“I do think it is passing the ball of responsibility so to speak back and forth and sometimes you know the clinician might hold it a bit more sometimes it might be held by the service user a bit more and that might change throughout the journey”* (Pg. 7, 159-162)

A double-edged sword

This subtheme reflects the role the service has in influencing service user perception of the term personal responsibility. The construct was seen as holding the potential to generate positive or negative connotations to service users, which participants reported could depend on how the construct is 'delivered' and implemented in services. P10 describes how prior exposure to the word responsibility shapes negative associations, whilst P11 builds on this to highlight the need to change the traditional narrative with the word responsibility.

P10: *“I think I think a lot of people the way we're socialised the word responsibility has a dirty is a dirty word in some ways”* (Pg. 17, L386-387)

P11: *“maybe with understanding that it's a bit of a trying to see respo- personal responsibility in more of a positive way rather than a negative way... I think how we*

can more flip it on its head to maybe build up the positive side of responsibility then maybe we'll see a bit more of the unhelpful behaviours change” (Pg. 25-26, L590-597)

Despite this, participants identified the link with wellbeing and that once taking personal responsibility was successful, the benefits would continue to reinforce it positively. Nevertheless, when expectations become too high, personal responsibility could be viewed as a burden to service users, with negative consequences and results in individuals disengaging. The notion of a double-edged sword also reflected a sense of cutting both ways. When personal responsibility is seen as a burden, negative consequences are felt by the service user and service. P10 and P7 describe how poor delivery of personal responsibility can cause disengagement and mental health difficulties.

P10: “I think there’s a fine line in terms of the continuum here because on one hand yes the service user should be empowered they should have that personal responsibility they should be able to do as many things as they can you know things like least restrictive practice things like that so they should be able to do as much as they can then on the other hand though some of the service users struggle massively with this and they can almost see it as a sense of pressure being expected to do things that they’re not in their comfort zone in but pushes them to an extreme that their mental states deteriorates” (Pg. 6-7, L141-147)

P7: “And then they can’t live up to it and then they feel bad and then they won’t try any more” (Pg. 22, L520)

A catch-22 situation

This subtheme presents the 'catch-22 situation' in which service users are placed in by secure mental health services. Participants identified factors required for personal responsibility, yet, also stated that these factors were also the result of taking personal responsibility. One such example is independence. This is demonstrated in how P9 reports personal responsibility is required in order to have independence, and P10 reports how independence is the result of personal responsibility.

P9: “I had to today to say can you be more responsible please cause you want to do this and be more independent but with it comes a level of responsibility... it’s that independence that doesn’t come if you’re not being responsible” (Pg. 24, L546-554)

P10: “you need them to actually have the personal responsibility... to be able to take a certain level of help and then go off on their own kind of like a student who learns from a teacher but then takes the teaching and does things themselves afterwards” (Pg. 6, L342-345)

These factors suggest a paradoxical situation where service users may have difficulty taking personal responsibility due to mutually dependent conditions. Availability of these factors depends on the service making these available to the service user, rather than the service user's ability to initiate these, as captured by P5.

P5: “where a lot of us might develop our personal responsibility patients might not have the opportunity... so where do they practice where to they practice their personal responsibility and develop it” (P5, 372-378)

This subtheme was also reflected in participants identifying personal responsibility as an area that service users of forensic mental health services have inherent difficulty with. However, it is required for them in order to be discharged to the community. P1 describes this as a contradiction.

P1: *“that is a bit of a contradiction in turn because those are the things that they inherently struggle with... people say it sometimes in a sense of well well it’s your [emphasised tone] responsibility if you want to get out of hospital... we say well it’s up to you it’s your responsibility to make sure however we are the treatment providers (laugh)”* (Pg. 5-6, L76-150)

Triangulation: Service User Focus Group Data

As outlined in the methodology, data from the service user focus group were organised into response summaries of topics and agreements and disagreement between the data were coded. Parallels and contrasts between the data have been identified.

Parallels Within the Data

There was much consensus in the data of staff and service users. When defining the construct, service users often drew upon concrete examples of personal responsibility, including daily activities, their future, and relationships with family. This can be seen as mirroring the different levels that staff crafted when describing the construct, moving from self to the environment and others. Service user participants also reported opportunities would need to be required in order to take personal responsibility, a direct parallel with staff. This also appeared to relate to the power held by services, as illustrated by P2, reporting that it was *“belittling if you don’t have any chances”*.

Participants further identified that taking personal responsibility caused consequences which ranged from negative and positive. This can be seen in the staff data. Of note, positives were not specified until service users were asked what taking personal responsibility would look like for a service user, to which positive consequences were reported. P5 explained, *“life’s improving”*.

Significantly, P2 described a negative consequence if expectations became high; *“could it be manipulative? expectations and end up doing it all the time”*. This further captures the idea of personal responsibility being perceived as a burden, which staff participants also identified. In line with consequences, service user participants spoke of needing to apologise for actions or owning up to behaviour. This included acceptance of blame as a way to move forward. P6 stated, *“If you’ve done something wrong you need to take the blame”*. This may have ties to accountability and consequences of actions, as found in the third theme in the analysis of staff participant data.

Contrasts Within the Data

There appeared to be two areas of disagreement between the staff and service user participants. Service user participants identified a behavioural component of personal responsibility in that personal responsibility required action, and the absence of personal responsibility looked like an absence of change. Whilst this aligned, the service users did not discuss any additional components of the construct. This greatly contrasts with staff participants, who detailed behavioural components as just one aspect, identifying further cognitive, emotional, and moral components.

Moreover, there was an absence of the ‘joint’ element that staff participants frequently discussed, with no discussion of staff aiding the processes of building personal responsibility.

Service user participants instead emphasised that this was solely held by the individual, as summarised by P2 “*It’s up to you on your own back*” and P1 “*your actions it’s down to you*”.

Discussion

This exploration of personal responsibility in forensic mental health sought to better understand the construct within this setting, with further interest in how it is integrated into services. The findings indicate that personal responsibility is ill-understood. However, a pathway to building the construct was identified. Furthermore, an acknowledged conflict with the service was seen as integral to contextualising the construct. Three main themes were identified in the analysis; 'I actually do not have a very clear idea', 'Building blocks', and 'Personal responsibility is not located in the individual'. The results and implications of the research are discussed in relation to existing literature.

Personal responsibility is embedded within forensic mental health research. However, most striking from this study is its lack of understanding, as captured in the first theme. This may be unexpected given the professional disciplines of the participant group. The majority of participants were either qualified Psychologists (n= 4 [36%]) or qualified Occupational Therapists (n= 4 [36%]) who are likely to be exposed to models of recovery and concepts related to personal responsibility in their qualification and practice. This is supported in the subtheme of ‘internal processes’ where participants cited self-efficacy and self-esteem as intertwined with personal responsibility. Despite this, the understanding of, or active engagement with, personal responsibility was not found. Poor understanding is comprehended as a reflection of the complexity of the client population in this setting, with the difference between forensic mental health and other populations emphasised in the analysis, as well as a lack of use of the term. The broader literature helps to clarify these findings. Within it, there is much published concern about the applicability of the recovery

paradigm in forensic mental health settings (Dorkins & Adshead, 2011; Simpson & Penney, 2011). Specifically, regarding personal responsibility, it has been argued simply that the two may be incompatible (Pouncey & Lukens, 2010). The viewpoint stems from the sentencing process within the criminal justice system (CJS).

Pouncey and Lukens (2010) note the key points of self-determination, responsibility, and empowerment within the recovery model do not reconcile with individuals deemed not criminally responsible. While criminal responsibility should not be considered the same as personal responsibility, Tomlin (2019) notes the CJS uses a medical model to determine criminally responsibility, which separates the mental illness from the individual. In comparison, the recovery paradigm proposes mental health as fundamentally related to an individual's identity, and an individual can live alongside mental illness and take responsibility through empowerment. The difficulty herein lies; individuals in these settings may have had their mental health difficulties externalised and thus absolved responsibility. For services to later promote a recovery model through taking responsibility for their mental health, conflict, difficulties, and confusion may arise.

Furthermore, within forensic mental health services, specific practices are noted to exacerbate the gap. For example, Mann et al. (2014) note a common lack of transparency in the risk assessment process which encourages a lack of responsibility of the service user. Until the systems around service users and clinicians adapt or find a shared understanding that can reconcile the conflicting systems, personal responsibility may remain problematic. This may suggest the confusion in being able to define and understand the construct as found in the current study.

Despite the outlined difficulties, participants did identify behavioural, emotional, cognitive, and moral components to personal responsibility. The formation identified is significant as it aligns with the structure of the Personal Responsibility Scale (Mergler &

Shield, 2016). The similarities may suggest some generalisability to defining the term across different psychological fields. Likewise, the moral component noted in the current study and Personal Responsibility Scale can be seen as gestured to in the offender treatment literature. Levenson (2011) suggests personal responsibility is included in offending treatment programmes by requiring acceptance of responsibility for the offence. This is driven by the ethics of society. The paper suggests taking accountability and making amends as key parts of responsibility which are components of creating a moral society and therapeutic change. The current study captures the underlying themes of a moral component being significant to the construct, as well as the role of society and accountability, signifying consensus with offending literature also.

The study further identified building blocks to increase a service user's personal responsibility. The subthemes noted internal and external factors, which were also required to be applied in collaboration with one another. Looking towards the literature, this appears to align with the recovery model proposed by Jacobson and Greenley (2001). The model emphasises a connection between the internal experience of an individual and the external conditions. Interestingly, this model was initially proposed to create specific strategies to ground the abstract concepts of recovery. The second theme of the current study may also reflect the same aim of grounding the construct following the difficulties participants had in defining personal responsibility. Whilst the Jacobson and Greenley model suggests personal responsibility to be an internal condition; there is clear support for recovery components to require both internal and external processes, as also concluded in this study. Once more, the authors of the recovery model propose a need for collaborative relationships between providers and service users, empowering both parties, allowing meaningful power-sharing and a more mutual assumption of responsibility. This is similarly reflected in the second and third theme of the present study.

Likewise, the study revealed a joint aspect in personal responsibility, including staff participants viewing the construct as being based within interpersonal interactions and grounded in society. This finding has also been highlighted in the recovery model. Indeed, all aspects of recovery have been suggested to be underpinned by interpersonal relationships (Price-Robertson et al., 2017). However, the current study differs as this was not reflected in the service user focus group data. One hypothesis for this may be due dynamics identified in the final theme noting the control of the service and potential influence of the subtheme regarding power.

The second theme of 'building blocks' also found ties with self-concept constructs as part of the internal processes of personal responsibility. This is of significance for forensic mental health as literature demonstrates individuals who experience involuntary inpatient care were found to experience negative changes in self-concept, including reduced self-efficacy (Hughes et al., 2009). Additionally, within offender treatment literature, a connection can also be seen. Maruna (2001) proposes offender's taking responsibility for one's own damaging behaviour increases an individual's self-belief of change, suggesting a positive relationship with self-efficacy. The results of the current study suggest self-concept constructs are influential in personal responsibility; thus, the role of personal responsibility in this setting should be considered in the context of a population that may have a negative view of self, however aiming to build personal responsibility may be beneficial.

Literature also supports the notion of how personal responsibility is conveyed can change the perception and consequences of the construct. Where others attribute personal responsibility to an individual through a judgement, a relationship with stigma and blame has been found (Feldman & Crandall, 2007; Mantler et al., 2003; Foster & O'Mealey, 2021). This contrasts with recovery model literature, where the individual takes personal responsibility through self-determination, and thus is associated with empowerment. The current study

supports the distinction between how an individual accesses personal responsibility through the findings of how a forensic mental health service delivers the concept.

The final theme of the current study highlighted the control held by the service in the development of personal responsibility. An area of interest is the finding of power influencing personal responsibility. The term is embedded into the empowerment component with the CHIME model of recovery. The current study supports this. However, it also evidences the short distance between empowerment and disempowerment in forensic mental health. The presence of power imbalances in forensic mental health is well-founded and noted at numerous levels (Kelly, 2006; Perlin, 1991), with power noted to be a barrier or facilitator in recovery depending if this is balanced or imbalanced between service user and the service (Wyder et al., 2013). Therefore, this study is concurrent with this literature.

Implications

The study highlights the complexities of applying personal responsibility in a forensic mental health environment and casts light on implications for clinical practice and future research.

The findings stress a lack of awareness or discussion of the construct in this setting; yet also provides methods to integrate it into services by identifying required elements. These may be used in clinical practice to outline areas of need in treatment or service conditions. Specifically, clinicians would benefit from an increase awareness of how the term is currently used within the service, working with service users to increase knowledge of an agreed definition and reduce potential stigma. If increasing personal responsibility is a treatment aim, great consideration should be given to this. The findings suggest this should take a collaborative approach, working towards making the construct an explicit goal and providing opportunities to trial behaviour change. This may be managed through suitable positive risk

taking, role modelling by staff or peers, and ensuring errors are made to be safe learning opportunities. The term, and intervention approach, should also be considered in line with other constructs given the suggested relationships in these findings. Clinicians may benefit from monitoring self-esteem, self-efficacy, or motivation prior to addressing personal responsibility to consider treatment priority and approach.

Regarding research implications, the current study focused on gathering an understanding of personal responsibility and its current integration into services. Participants identified processes to its integration, as well as the potential barriers to this through role of the service. Consequently, it may be beneficial for a qualitative study to explicitly explore barriers to building personal responsibility in forensic mental health services with staff to explore this further. Additionally, whilst the service user perspective was gathered as a form of triangulation in the current study, the research would benefit from the construct being explored in greater depth with service users. This would align with recovery principles, work towards power-sharing, and may be able to elaborate on the differences found in the current study.

Further consideration should also be given to the potential alignment in the definition of personal responsibility with the structure of the Personal Responsibility Scale (Mergler & Shield, 2016). This finding may indicate potential quantification of the construct in this setting. Future research may want to evidence the structure found in this study in greater detail, from which the applicability of validating a quantitative measure of personal responsibility within a forensic mental health setting may be feasible. This is significant in aiding the conceptualisation, which has been highlighted as poor in the current study.

Strengths and Limitations

The current study captures the unique experiences of the participants. It is the first qualitative study to date that has specifically explored how personal responsibility is understood for forensic mental health service users. Steps have been taken to ensure credibility of the analysis, including the researcher maintaining a reflective research journal and attendance to qualitative workshops, which both provided reflections of epistemology, challenges to any assumptions held, and coherence throughout the analysis. Data triangulation was also used, with the benefits of evidencing validity to the findings and showcasing service user perspective.

The qualitative design of the study reflects the views and experiences of the participants. All participants, staff and service users, were recruited from the same specialist service. Therefore, the organisation's ethos may be influential in the results and participant perspectives may have been shaped by shared experiences of the service. This could be considered significant given the frequent occurrence of external factors being cited as influential to personal responsibility in the analysis. Furthermore, the researcher was familiar with the service. Familiarity could have resulted in some implicit influences of the service being missed.

A single researcher completed the interviews and analysis. Reflexive TA emphasises the analysis is reflective of the researcher's subjectivity. Thus, this should be considered in contextualising the findings. Still, measures were taken to strengthen the analysis to ensure a nuanced and insightful analysis.

A further drawback of the study lies with the limited service user data. The requirement for a multiple-perspective paradigm in mental health research has been stipulated to advance the evidence base and influence policy (Rose et al., 2006). Thus, the current study would have had greater guidance to the literature given equal representation of the different stakeholders in forensic mental health services.

Reflections

It is important to note that participants were not provided with a definition of personal responsibility, as the study aimed to elicit participants' understanding of the construct. Thus, the findings account for the idiosyncratic experiences of the participants. A learning process for participants was observed through each of the interviews, which resulted in changes in the participants' perception and potential change in the application of the construct by the end of the interview. Participants consistently commented that they had not previously spent this length of time considering the construct before. Moreover, it was reported that partaking in the study led to greater contemplation and the potential for altered clinical practice going forward.

Conclusion

This qualitative research adds value to the forensic mental health evidence base by exploring the construct of personal responsibility. The experiences of clinicians working in forensic mental health highlighted three central themes. These demonstrate the complexity of the construct and the uncertainty held by clinicians regarding it, whilst emphasising the control held by services and the internal and external processes required to influence it. This study has provided novel insights into the complexity of personal responsibility in this setting and has been able to draw links to several different paradigms within the literature. The contributions provided by all participants have also highlighted the importance of working collaboratively to identify the appropriate role personal responsibility can have in forensic mental health moving forward.

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PRESS RELEASES

The Use of Quantitative Measures of Personal Recovery in Forensic Populations: A Systematic Review

Current personal recovery outcome measures are appropriate for forensic settings, but more work is still required. A recent review of published literature examined how personal recovery in mental health is measured in forensic settings. The findings conclude two tools may be suitable for use in these environments, with results that parallel and contrast to clinical settings.

Personal recovery refers to an individual's idea of progress and includes leading a fulfilling life alongside mental health difficulties. It is 'recovery in' rather than 'recovery from' illness (Davidson & Roe, 2007). The importance of this in mental health services has led to the making of tools to assess if individuals are achieving this. However, there had been no review of these tools for individuals in forensic settings who experience mental health difficulties until now. The review examined all published research for individuals detained under the Mental Health Act or involved with the Criminal Justice System, where personal recovery was measured. It investigated which personal recovery measures were used, how they were applied, and what they found. By answering these questions, the review concluded if the measures were suitable in this different context. The quality of the research was also scrutinised.

The review found that despite there being up to 35 different tools to measure a change in personal recovery (Moreno & Uriarte, 2019), just four were discovered to be used in forensic settings. These tools found a change in personal recovery through several interventions. Still, differences in personal recovery were only successful when the intervention directly targeted recovery. This is when the researchers set out to change personal recovery specifically. The review also reports how personal recovery relates to other concepts, such as empowerment and recovery-orientated care. This is similar to clinical

settings such as the community. However, the review warns of the inadequate quality of some of the research. Some papers failed to report important details about the measure they used or other information of their research.

Overall, the review recommends two of the measures to be appropriate for forensic settings, the Recovery Assessment Scale (Giffort et al., 1995) and the Mental Health Recovery Measure (Young & Bullock, 2003). It highlights what is needed to consider when assessing personal recovery in forensic settings, which can benefit working practices in mental health. It also recommends directions for future research that is essential for greater confidence in using measures of personal recovery.

The research was conducted as part of a doctorate in Forensic Clinical Psychology at the University of Birmingham, funded by St Andrews Healthcare.

Staff Perception of Personal Responsibility in Forensic Mental Health Services: A Thematic Analysis

Personal responsibility in forensic mental health is found to be anything but personal. A new study examines the complexity of personal responsibility, leading to an improved understanding of forensic mental health recovery.

Experts have previously reported the need for personal responsibility to be taken in offender treatment and mental health recovery (McGrath et al., 2009; Gulayets & Sawyer, 2020). However, little was known for individuals who require both. The study is the first to examine how personal responsibility is understood in this circumstance. It specifically focuses on the responsibility individuals have for their lives in secure psychiatric hospitals, including mental health and risk to themselves or others. The study does not examine criminal responsibility, the acceptance of a crime, which takes place in the courts instead.

The research gained the opinions of 11 clinicians working in forensic mental health settings and six service users. Clinicians, ranging from nursing, psychology, and occupational therapy professions, shared their thoughts in interviews. Whilst service users discussed personal responsibility and its meaning to them, in a focus group together. The results showed personal responsibility is yet to be confidently understood. But it is thought to be made up of a person's behaviour, thoughts, emotions, and moral guise, with changes expected in all of these if someone is taking personal responsibility.

When it comes to increasing personal responsibility, the study reports internal and external processes are needed. This includes changes from the individual and the environment. Likewise, an individual needs change on the inside as much as they do on the outside. Internal processes refer to the link between an individual's ability to take personal responsibility and their identity, including their self-esteem and motivation. Clinician's also reported the need for personal responsibility to be meaningful to the person if a change was to

happen. External processes include the role of clinicians in the change process and the need for visible outward change. Yet, in a surprising contrast, service users reported all change was down to the individual, reducing the role of external help.

The research also noticed the vast complexity created when there are offending and mental health needs. It acknowledges the careful balance between the control secure services have and letting individuals take personal responsibility for their lives. The study captures the debate of who holds accountability for an individual's actions in such a setting. Even more so, it highlights negative associations with the word responsibility and the problem of 'catch-22' situations. People in these services cannot increase personal responsibility without achieving something else first, such as independence or being safe. But they cannot be considered independent or safe unless they are considered personally responsible. So, the research ponders, for forensic mental health service users, what comes first, the chicken or the egg?

The research highlights a real opportunity to increase the understanding and reduce the potential stigma of the word responsibility. It concludes by offering guidance to forensic mental health professionals, including increasing clinicians' and service users' conversations about personal responsibility. It also outlines what is needed to increase an individual's personal responsibility. Finally, the study recommends further research to investigate the ability to measure a change in personal responsibility based on its findings.

The research was conducted as part of a doctorate in Forensic Clinical Psychology at the University of Birmingham, funded by St Andrews Healthcare.

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APPENDICES

Appendix A: Papers excluded at the Eligibility Stage

Paper	Reason for Exclusion	Justification
Eckert, Schel, Kennedy & Bulten, 2017	Inappropriate Measure	<p>This paper uses the DUNDRUM-4, a subscale of the Dangerousness Understanding, Recovery and Urgency Manual (DUNDRUM).</p> <p>The DUNDRUM was designed to aid decision making between levels of therapeutic security. The DUNDRUM is completed by staff, however there is a self-report version available. The items of DUNDRUM-4 are stability, insight, therapeutic rapport, leave, dynamic risk items, victim sensitivity.</p> <p>This paper uses the staff rated DUNDRUM-4, failing to meet the self-report of an internal state criterion. Furthermore, the items fail to reflect the definition of ‘personal recovery’ as outlined by the literature.</p>
Green, Batson & Gudjonsson, 2011	Inappropriate Measure	<p>This paper uses the Recovery Journey Questionnaire (RJQ). Whilst the RJQ is a self-report measure, it aims to measure service-users' experience of recovery, rather than personal recovery. The items are working together, support and preparation, empowering service users, providing good models, and things to do.</p> <p>The items fail to reflect the definition of ‘personal recovery’ as outlined by the literature, making the measure inappropriate.</p>
Gudjonsson, Savona, Green & Terry, 2011	Inappropriate Measure	<p>This paper uses the Recovery Journey Questionnaire (RJQ). Please see a description of the measure above.</p> <p>The items fail to reflect the definition of ‘personal recovery’ as outlined by the literature, making the measure inappropriate.</p>
Turgoose, Busuttil, Ashwick, Booth & Murphy, 2018	Inappropriate Concept of Recovery	<p>This paper uses the Recovery Star. The Recovery Star has two aims; for service users to rate progress in the item areas, and for services to measure effectiveness.</p> <p>The items are Managing mental health, Physical health & self-care, Living skills, Social networks, Work, Relationships,</p>

		<p>Addictive behaviour, Responsibilities, Identity & self-esteem, and Trust & hope.</p> <p>The paper uses the measure to assess areas of functioning typically affected by substance misuse. It does not aim to measure personal recovery.</p>
Moynihan, O'Reilly, O'Connor & Kennedy, 2018	Inappropriate Measure	<p>This paper uses the DUNDRUM-4, a subscale of the DUNDRUM. Please see a description of the measure above.</p> <p>This paper uses the staff rated DUNDRUM-4, failing to meet the self-report of an internal state criterion. Furthermore, the items fail to reflect the definition of 'personal recovery' as outlined by the literature.</p>
Adams, Thomas, Mackinnon & Eggleton, 2018	Inappropriate Measure	<p>This paper uses the DUNDRUM-4, a subscale of the DUNDRUM. Please see a description of the measure above.</p> <p>This paper uses the staff rated DUNDRUM-4, failing to meet the self-report of an internal state criterion. Furthermore, the items fail to reflect the definition of 'personal recovery' as outlined by the literature.</p>
Davoren, Hennessy, Conway, Marrinan, Gill & Kennedy, 2015	Inappropriate Measure	<p>This paper uses the DUNDRUM-4, a subscale of the DUNDRUM. Please see a description of the measure above.</p> <p>This paper uses the staff rated DUNDRUM-4, failing to meet the self-report of an internal state criterion. Furthermore, the items fail to reflect the definition of 'personal recovery' as outlined by the literature.</p>
Nagi, Davies & Shine, 2014	Inappropriate Concept of Recovery and Measure	<p>This paper uses the Treatment & Recovery Questionnaire (TRQ).</p> <p>The TRQ assesses an individual knowledge of different domains relevant to recovery including mental health symptoms, substance misuse, stressors, early warning signs, risky behaviours and coping strategies. There is no published psychometric testing on this questionnaire.</p> <p>This paper fails to meet the inclusion criteria of a validated measure, nor aligning with the definition of 'personal recovery'</p>

		as outlined by the literature.
Abidin, Davoren, Naughton, Gibbons, Nulty & Kennedy, 2013	Inappropriate Measure	This paper uses the DUNDRUM-4, a subscale of the DUNDRUM. Please see a description of the measure above. This paper uses the staff rated DUNDRUM-4, failing to meet the self-report of an internal state criterion. Furthermore, the items fail to reflect the definition of ‘personal recovery’ as outlined by the literature.
Davoren, Abidin, Naughton, Gibbons, Nulty, Wright & Kennedy, 2013	Inappropriate Measure	This paper uses the DUNDRUM-4, a subscale of the DUNDRUM. Please see a description of the measure above. This paper uses the staff rated DUNDRUM-4, failing to meet the self-report of an internal state criterion. Furthermore, the items fail to reflect the definition of ‘personal recovery’ as outlined by the literature.
Davoren, O'Dwyer, Abidin, Naughton, Gibbons, Doyle, E., ... & Kennedy, 2012	Inappropriate Measure	This paper uses the DUNDRUM-4, a subscale of the DUNDRUM. Please see a description of the measure above. This paper uses the staff rated DUNDRUM-4, failing to meet the self-report of an internal state criterion. Furthermore, the items fail to reflect the definition of ‘personal recovery’ as outlined by the literature.
Doyle, Logan, Ludlow & Holloway, 2012	Inappropriate Measure	This paper aims to validate the Milestones to Recovery Scale (MTRS). The MTRS is completed by staff from observations, with the items being level of distress, insight, coping strategies, challenging behaviour, substance use, absconding, control, withdrawal, interactions, activity, psychological interventions. The MTRS does not meet the criterion of being a self-report of an internal state nor do the items reflect the definition of ‘personal recovery’ as outlined by the literature.
Donoghue, Lyne, Hill, O'Rourke,	Inappropriate Concept of Recovery	This paper used the Recovery Style Questionnaire (RSQ). The RSQ is a self-report measure that aims to determine an

Daly, Larkin, ... & O'Callaghan, 2011		individual's recovery style. The RSQ therefore fails to meet the inclusion criterion of measuring personal recovery.
Lofthus, Westerlund, Bjørgen, Lindstrøm, Lauveng, Rose, ... & Heiervang, 2018	Inappropriate Population	This paper uses a population that is not reflective of a forensic population. The participants are in the community, with only 47% receiving treatment under a community treatment order (CTO). The participants do not meet the criteria of a forensic population, defined as defined as any individual who has been detained and/or a history of involvement in the criminal justice system.
Coffey, Hannigan, Barlow, Cartwright, Cohen, Faulkner, ... & Simpson, 2019	Inappropriate Concept of Recovery	The paper uses the Recovery Self-Assessment Scale (RSA). The RSA aim to measure the extent of recovery-oriented practices of a service. The items fall into five domains; life goals, involvement, treatment options, choice and individually tailored services. The RSA fails to meet the inclusion criterion of measuring personal recovery.

Appendix B: Quality Assessment Criteria

Risk of Bias Score	Definition	Low Risk of Bias 2	Medium Risk of Bias 1	High Risk of Bias 0
<i>Selection Bias</i>	The presence of systematic differences in the characteristics of the participants selected for the study and those who are not. This can occur if participants are not equally or fairly selected, or pre-existing characteristic differences at baseline between participant groups.	The characteristics and recruitment of the participants are well defined and are likely to be representative of the target population. If there are multiple groups, for the participants to be recruited from the same population and within the same time period. If there are groups to be compared, strategies have been implemented e.g., randomly assigned, matching.	Some participant characteristics are reported. There may be insufficient information to decipher the presence of selection bias and/or the recruitment process is not clear. Participants may be recruited from a targeted population.	The participant characteristics and/or recruitment process are not described. Participant characteristics are provided which identifies pre-existing characteristic differences between groups with no control measures taken.
<i>Detection Bias</i>	The presence of systematic differences in the how the outcomes are determined which effects the study's ability to detect the effect being examined. Bias could be present in how	The outcomes measures are clearly described. This includes details of the authors, items, subscales etc. Cronbach alpha has been reported indicating validity and reliability (above 0.7).	The outcome measures are described. Some information may be missing such as authors, items, subscales etc. Cronbach alpha has not been reported or has only been reported for some subscales.	The outcome measure is not clearly described. The outcome measure has poor reliability and validity reported. Cronbach alpha score was below 0.7.

	outcomes are collected or established.	In appropriate study designs, blinding is used.	Equally if the Cronbach alpha is reported for a related sample in previous research rather than the given study.	
<i>Generalisability</i>	The degree to which the results are applicable to other settings beyond the study.	The sample is sufficient in size and representational characteristics of the target population. A sufficient sample size is 100 or above.	There may be a smaller sample size and/or the presence of some idiosyncratic features that may not be representative of the target population as a whole. Sample sizes may be between 30-100.	A small sample size, and/or the presents of idiosyncratic features of the participants that may not be representative of the target population as a whole. Sample sizes may be below 30.
<i>Analyses</i>	The analysis is appropriate for the study aim and design.	The analysis is described and appropriate for the study (e.g., the analysis is conducted at the appropriate level; unit, individual etc.). A power calculation may also be detailed to evidence a sufficient sample size for the analysis.	The analysis is given. Yet, it may not be clear as to how and why this analysis was conducted.	A basic overview of the analysis is given. It is inappropriate for the aim of the study (e.g., inappropriate level of analysis).
<i>Reporting Bias</i>	The systematic differences between the reported and unreported findings.	Outcome measures are consistently administered to all participants.	Not all participants are included in the analyses, yet a defensible rationale is provided.	Not all outcomes measures are consistently administered to participants, and/or not all

	This may be selective reporting of outcomes depending on the nature of the results.	The data for all participants is included in the final analyses. All analyses are reported, with the appropriate statistics presented (e.g., mean and standard deviation). Data is displayed in tables and/or figures.	Selected statistics are presented (e.g., mean and standard deviations for some of the subscales) and/or not all are presented in tables and figures.	participants are included in the analyses. No rationale is provided. Results may be reported globally across groups and/or results only reported for some groups. No statistics (e.g., mean and standard deviation) are presented within the results. Tables and figures are not used.
<i>Attrition Bias</i>	The systematic differences between participants who remain in the study and those that do not. Withdrawals from the study include participants who have dropped out of the study, or those researchers have chosen to omit.	The number of participants who withdrew/were excluded is given. The characteristics of the participants and reasons for their withdrawal are also detailed. If no participants withdrew, it can be considered a low risk of bias.	The number of participants who withdrew/were excluded is given. Information regarding the characteristics, and reason for withdrawals is limited/unclear.	No information is given regarding withdrawals from the study.

For randomised controlled trial studies only.

<p><i>Intervention Integrity</i></p>	<p>Upheld by participants receiving a well conceptualised intervention, that is delivered as intended.</p> <p>Intervention integrity can be met by assurance of adherence (delivered as intended), exposure (appropriate length and frequency), quality of delivery (e.g., facilitator training, preparedness), participant responsiveness (e.g. participation and/or enthusiasm), and program differentiation (delivery of unique features of the intervention).</p>	<p>The study reports on the maintenance of intervention integrity by detailing methods of assuring at least two of the following aspects: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation.</p>	<p>The study reports on the maintenance of intervention integrity by detailing methods of assuring at least one of the following aspects: adherence, exposure, quality of delivery, participant responsiveness, and program differentiation.</p>	<p>The study does not report methods to maintain the intervention integrity.</p>
<p><i>Confounders</i></p>	<p>A variable associated with the intervention/exposure that causally relates to the outcome of interest.</p>	<p>Relevant confounders are acknowledged and controlled for. Researchers may do this by the design (e.g., stratification or matching) or in the analysis.</p>	<p>Confounders are acknowledged, with some of these controlled for.</p>	<p>Little to none of the relevant confounders are controlled for.</p>

		Researchers report that groups were balanced at baseline in relation to confounding variables.		
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Overall Rating	High risk of bias	Moderate risk of bias	Low risk of bias
Requirements	≤33%	33-66%	66-100%
Percentage & Score	(0-4) RCT (0-5)	(5-8) RCT (6-10)	(8+) RCT (11+)

Appendix C: Justification in The Quality Appraisal Rating

Component	Studies					
Ratings	Ahmed et al., 2015	Bartholomew, Morgan, Mitchell and Van Horn, 2018	Bond et al., 2015	Compton et al., 2016	Jas and Wieling, 2018	Livingston, Nijdam-Jones, Lapsley, Calderwood, and Brink, 2013 <u>Cross-sectional design</u>
<i>Selection Bias</i>	Participant characteristics and recruitment process is clear. Both the intervention and control groups have been recruited from the same population and their allocation randomised.	Detailed participant characteristics are provided with clear procedures for the recruitment process.	Recruitment process and participant characteristics are given. Both the intervention and control groups have been recruited from the same population and their allocation randomised.	Recruitment process and participant characteristics are described.	Participant characteristics and recruitment process is described clearly.	Participant characteristics and recruitment process is described clearly.
<i>Detection Bias</i>	The outcome	The measures are	The outcome	The outcome	The outcome	The outcome

	measures are given, but there are no details provided (e.g. authors, subscales, validity and reliability). Blinding is used for their administration.	described in detail (author, items, subscales) with reported reliability and validity. Cronbach alpha on the measures are reported, with all above 0.7.	measures are described, including details of subscales. However, there are no details for reliability and validity such as Cronbach alpha being reported.	measures are described with reference to reliability and validity. Cronbach alpha on the measures are reported, with all above 0.7.	measures are described in detail (author, items, subscales) with reported reliability and validity. Cronbach alpha on the measures are reported, with all above 0.7.	measures are described in detail (author, items, subscales) with reported reliability and validity. Cronbach alpha on the measures are reported, with all above 0.7.
<i>Generalisability</i>	The sample (n=78) were recruited from services in a specific region. There may be some idiosyncratic features present.	The sample (n= 230) were recruited over a number of different services and geographic locations within the USA. They appear appropriately representative of the target population.	The sample (n= 90) were recruited from multiple sites of a service. There may be some idiosyncratic features present.	The sample (n= 100) were recruited across 34 counties, across multiple services.	The sample (n= 127) were recruited from two sites. There may be some idiosyncratic features present.	The sample (n= 58; patients n= 30, providers n= 28) were recruited from one hospital site. There may be some idiosyncratic features present.
<i>Analyses</i>	All analyses are described, including	Details of analyses are given, including	All analyses are described, with	The analysis is described and is	All analysis is described and is	All analysis is described and is

	<p>details such as level set for significance. Analyses are conducted at different levels (individual, group) where appropriate.</p>	<p>data cleaning and preparation before these were conducted. These were conducted at appropriate levels (e.g., unit – ACT vs FACT). Demographic differences between the groups were statistically analysed and relevant variables entered as covariates in the appropriate analyses.</p>	<p>reasons provided e.g., choice due to skewed distributions.</p>	<p>appropriate for the study hypotheses.</p>	<p>appropriate for the study hypotheses.</p>	<p>appropriate for the study hypotheses.</p>
<i>Reporting Bias</i>	<p>Intent-to-treat analysis was used; therefore, all participants were included. All means</p>	<p>All analyses are reported. Where items have been removed from the analysis, reasons</p>	<p>Intent-to-treat analysis was used; therefore, all participants were included. Tables are</p>	<p>All analyses are reported. Appropriate statistics are given and displayed in</p>	<p>All analyses are reported. Appropriate statistics are given and displayed in</p>	<p>All analyses are reported. Appropriate statistics are given and displayed in</p>

	and standard deviation are given, with tables and figures used.	are provided. Appropriate statistics are given and displayed in tables.	used to present statistics. Yet not all statistics are given (e.g., recovery from baseline to follow up).	tables.	tables.	tables.
<i>Attrition Bias</i>	The number of participants excluded from the study and those that dropped out are given. Some additional details regarding the reasons for this are given.	The number of participants excluded is provided, with the reason given. There were no dropouts.	The number of participants excluded, from drop out and removal by the researchers, is provided with specific reasons. There is no comparison of demographic information given.	The number of participants excluded, from drop out and removal by the researchers, is provided with specific reasons. A comparison of demographic information is given.	The number of participants excluded, from drop out and removal by the researchers, is provided with specific reasons. A comparison of demographic information is given.	No participants withdrew, from the study.

For randomised controlled trial studies only.

<i>Intervention Integrity</i>	Computer programmes and structured session plans were used to	N/A	A measure for programme fidelity was used to ensure appropriate	N/A	N/A	N/A
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	adherence, exposure and program differentiation.		adherence. A one-item measure of satisfaction with vocational services was used to assess participant responsiveness.			
<i>Confounders</i>	Participants are exposed to other interventions, however both groups have matched exposure. Demographic and clinical characteristics are reported at baseline to show no significant difference.	N/A	Confounders are not considered or controlled for in the study. A confounder is acknowledged in the study limitations.	N/A	N/A	N/A
Overall Rating	<u>LOW</u>	<u>LOW</u>	<u>MODERATE</u>	<u>LOW</u>	<u>LOW</u>	<u>LOW</u>

Component	Studies				
Ratings	Livingston, Nijdam-Jones, Lapsley, Calderwood, and Brink, 2013 <u>Pre-post study design</u>	Kopelovich, Yanos, Pratt and Koerner, 2013	MacInnes et al., 2016	Pratt, Koerner, Alexander, Yanos and Kopelovich, 2013	Sveinsdottir and Bond, 2017
<i>Selection Bias</i>	Participant characteristics for both groups are provided, however the recruitment process is not clear.	Participant characteristics are given. All courts were recruited from within the same three-month period. There are some significant differences between participants in different courts which is acknowledged, and methodology adjusted to reflect this. The recruitment process is given; however, some	Participants characteristics are provided in good detail, with a clear recruitment process reported.	Participant characteristics are given. All courts were recruited from within the same three-month period. There are some significant differences between participants in different courts which is acknowledged, and methodology adjusted to reflect this. The recruitment process is given; however, some	Participant characteristic are provided; however, these are not presented to compare between intervention and control. Both groups were recruited from the sample.

		details are not clear (e.g., who approached individuals).		details are not clear (e.g., who approached individuals).	
<i>Detection Bias</i>	The outcome measures are described in detail (author, items, subscales) with reported reliability and validity. Cronbach alpha on the measures are reported, with all above 0.7.	The outcome measures are described in detail (author, items, subscales) with reported reliability and validity. Cronbach alpha on the measures are reported, with all above 0.7.	The outcome measures are reported. Details are only provided for one measure (primary outcome). There are no descriptions of reliability and validity for the secondary measures.	The outcome measures are described in detail (author, items, subscales) with reported reliability and validity. Cronbach alpha on the measures are reported, with all above 0.7.	The outcome measures are described in detail (author, items, subscales) however reliability and validity are not reported.
<i>Generalisability</i>	The sample (n= 58; patients n=30, providers n=28) were recruited from one hospital site. There may be some idiosyncratic features present.	The sample (n= 51) were recruited from four courts within one region. There may be some idiosyncratic features present. The authors recognise the small sample as a limitation.	The sample (n= 102) were recruited from six hospitals within two regions.	The sample (n= 51) were recruited from four courts within one region. There may be some idiosyncratic features present. The authors recognise the small sample as a limitation.	The sample (n= 87) were recruited from one rehabilitation organisation within one area. There may be some idiosyncratic features present.
<i>Analyses</i>	Analyses are described, with details of why the methods were chosen	Analyses are described. The authors report the small sample size and	The study is a cluster-randomised trial. It is recommended for	Analyses are described. The authors report the small sample size and	The study is a secondary analysis of a RCT. All analysis is described and

	<p>provided (e.g., to control for some confounders). A power calculation was calculated post hoc suggesting the study was underpowered, as described in the study limitations.</p>	<p>attrition to follow up as attenuating the study's statistical power. This caused the removal of two courts from a between-court analysis.</p>	<p>analyses to be conducted at individual level where possible. However due to the study being a pilot, they report a smaller sample size than required for this analysis and have thus conducted analyses at a unit level; reported to be suitable for such cases. An Intra-cluster Correlation Coefficient was calculated to assess the sample size required for a full trial; however, the value is not reported.</p>	<p>attrition to follow up as attenuating the study's statistical power. This caused the removal of two courts from a between-court analysis.</p>	<p>is appropriate for the study hypotheses.</p>
<i>Reporting Bias</i>	<p>Participants who withdrew during the study were excluded from the analyses. Appropriate statistics (e.g., mean, standard</p>	<p>Data was removed from some analyses due to poor sample size and withdrawals. Appropriate statistics (e.g., mean, standard</p>	<p>For individuals who were missing >20% of scores were removed from the analyses. In some analyses an average score was used</p>	<p>Data was removed from some analyses due to poor sample size and withdrawals. Appropriate statistics (e.g., mean, standard</p>	<p>Data for all participants are reported, with the appropriate statistics presented (e.g., mean and standard deviation). Data is displayed in</p>

	deviation) are provided in the results.	deviation) are provided in the results.	to substitute missing data. Appropriate statistics (e.g., mean, standard deviation) are provided in the results.	deviation) are provided in the results.	tables and/or figures.
<i>Attrition Bias</i>	The number of participant withdrawals is given, however there are no reasons provided for this or the characteristics of these participants provided.	Comparative statistics have been conducted to compare participants with those who withdrew. However, the characteristics of those who withdrew are not given. A reason for withdrawal is hypothesised only.	The number of participants excluded is provided, with specific reasons given. Some characterises of participants who withdrew are discussed.	There were no withdrawals reported in the study.	No information is given regarding withdrawals from the study.

For randomised controlled trial studies only.

<i>Intervention Integrity</i>	N/A	N/A	A training programme and practical handbook were provided to facilitators, some sessions were audio recorded and monthly	N/A	N/A
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			meetings were held to with the research assistant to review the intervention. These were used to ensure intervention adherence, quality of delivery, and program differentiation.		
<i>Confounders</i>	N/A	N/A	Baseline characteristics of intervention and control participants are provided to be compared, however statistical comparisons are not reported. There are no reported considerations of confounding factors.	N/A	N/A
Overall Rating	<u>MODERATE</u>	<u>MODERATE</u>	<u>MODERATE</u>	<u>MODERATE</u>	<u>MODERATE</u>

Appendix A: Published Personal Responsibility Measures

Scale	Reference	Field of Research	Factors within construct following factors analysis
Responsibility scale of the California Psychological Inventory	Martel, J., McKelvie, S. J., & Standing, L. (1987). Validity of an intuitive personality scale: Personal responsibility as a predictor of academic achievement. <i>Educational and Psychological Measurement</i> , 47(4), 1153-1163.	Education	N/A – No factor analysis conducted.
Responsibility Scale	Kluever, R. C., & Green, K. E. (1998). The responsibility scale: A research note on dissertation completion. <i>Educational and Psychological Measurement</i> , 58(3), 520-531.	Education	Two factors: ‘Is’, and ‘should be’.
10-Item Student Personal Responsibility Scale	Singg, S., & Ader, J. A. (2001). Development of the student personal responsibility scale-10. <i>Social Behavior and Personality</i> , 29(4), 331.	Education	One Factor: personal responsibility
Personal and Social Responsibility Questionnaire	Li, W., Wright, P. M., Rukavina, P. B., & Pickering, M. (2008). Measuring students’ perceptions of personal and social responsibility and the relationship to intrinsic	Education	Two factors: ‘effort’ and ‘self-direction’.

	motivation in urban physical education. <i>Journal of teaching in Physical Education</i> , 27(2), 167-178.		
Personal Responsibility Orientation to Self-Direction in Learning Scale	Stockdale, S. L., & Brockett, R. G. (2011). Development of the PRO-SDLS: A measure of self-direction in learning based on the personal responsibility orientation model. <i>Adult Education Quarterly</i> , 61(2), 161-180.	Education	'Four factors: 'initiative', 'self-efficacy', 'control', and 'motivation'.
Teacher Responsibility Scale	Lauermann, F., & Karabenick, S. A. (2013). The meaning and measure of teachers' sense of responsibility for educational outcomes. <i>Teaching and Teacher Education</i> , 30, 13-26.	Education	Four factors: 'responsibility for student motivation', 'responsibility for student achievement', 'relationship with students', and 'teaching'.
Personal Responsibility Scale	Mergler, A., & Shield, P. (2016). Development of the Personal Responsibility Scale for adolescents. <i>Journal of adolescence</i> , 51, 50-57.	Education	Three factors: 'personal accountability', 'behavioural and emotional control' and 'cognitive control'.

Appendix B: Changes to Methodology

The current study underwent significant modifications to the research question and protocol. This was due to the effect of COVID-19, with the government directed restrictions and the research site policy impacting the study during the data collection stage.

The original research protocol consisted of three stages to investigate the ability to create a quantitative measure of personal responsibility in forensic mental health. The protocol consisted of three stages and used a mixed-methods approach. The first stage had intended a qualitative approach to develop an understanding of the concept specific to this setting. This was to consist of focus groups, one to be facilitated with service users, and another focus group to be facilitated with staff. Following data analysis, themes from the focus group were then planned to be triangulated with literature in order to develop a measure of personal responsibility. This was to examine the face validity of the measure. The second stage also consisted of piloting the developed measure with service users. The final stage was to administer the questionnaire to a larger sample of service users at two time points, alongside the administration of the New General Self-Efficacy Scale (Chen et al., 2001). Analysis of the data was to consist of assessing internal consistency and correlation coefficients to assess construct validity and test-retest reliability.

Of note, the original protocol was acknowledged to be a significantly sized research project for the Forensic Clinical Psychology Doctorate. Therefore, during the development of the project and within the ethical application, approval was sought and granted to facilitate several focus groups and the project to focus on the expansion of stage one if stage two and three were unable to be achieved.

Data collection for the original study began in November 2019, with the service user focus group conducted on 26/11/2019. This explored how service users defined personal responsibility, its component, and how it could be demonstrated in the service. In March

2020 restrictions to access the research site were put in place in line with government and research site policy. Consequently, the research was halted, and the research protocol was reviewed. Access to the research site was not possible, and research projects with service users stopped. Thus, it was decided to expand stage one of the original protocol and shift the focus of the research to a greater understanding of the construct personal responsibility. Staff perspectives were sought for this for several reasons. Importantly, literature supported the role for clinicians to be involved in such forms of research due to their ability to connect policy and practice (Hardiman & Hodges, 2008). Furthermore, the staff focus group had not yet been conducted and staff members were still able to be accessed through remote methods to be in line with COVID-19 policy. The staff perspective was therefore chosen to be expanded upon, moving from focus groups to individual interviews. An application made to the University of Birmingham's Ethical Review to adapt the research, with approval granted on 27/04/2020. The resulting changes caused the project to become a qualitative study.

Reflections on the change of methodology

The changes made to the research is significant, however it remains true to the original intentions born from the field of literature. It continues to address the gap in the literature regarding the lack of exploration of personal responsibility in a forensic mental health context, however, takes a more in-depth approach to understand the concept than that of the original study design. I believe the changes benefitted the research by gathering a greater understanding of personal responsibility and finding data that may have been missed in the form of focus groups. Whilst the definition would have been sought in both study designs, the current study identified processes to integrating personal responsibility and the potential barriers which exist. I believe this enriches the literature adding novel insights. The greater exploration of the term also strengthens any future research that may look at using a

quantitative method due to the supportive conclusions of the study.

However, the change in methodology to a qualitative approach was unexpected and occurred within a short timeframe. This impacted the timeline of developing and reflecting on my own theoretical position. Ideally, I would have had greater awareness and understanding of my ontological and epistemological assumptions prior to the development of the adapted research questions. However, the required speed for the change to the study, including to ensure ethical approval, caused the research questions to be identified first. As a consequence, I took time to consider my theoretical position during the data collection process, as well as contemplating the change in significance of objectivity and subjectivity. The original method of a predominate quantitative approach valued objectivity, whereas the change, and in particular the use of Reflexive Thematic Analysis, valued subjectivity. I sought guidance on how to understand the successful use of subjectivity in qualitative research through academic texts (Braun & Clarke, 2013) and the attendance of qualitative workshops to ensure reflexivity. I did this by using the space to critically reflect on the themes and what role I had in producing this knowledge. I believe the steps I took during data collection and analysis mitigated the late development of theoretical position.

I also consider the value I took from the qualitative approach as a working practitioner. The current study highlighted many clinical applications and ignited my passion to integrate the term in my clinical practice as a Trainee Forensic Clinical Psychologist and to change the narrative around it. I was particularly struck by the theme of personal responsibility not being located within the individual and the power held by the service and clinicians. I do not think I could have captured these insights to the same extent if the study followed the original protocol.

Overall, I believe the study was strengthened by the change in protocol, as well as adapting research during an unprecedented time.

References

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. sage.

Appendix C: Semi-structured Interview Schedule

1. The research is focused on understanding the term personal responsibility, so to start, how would you define the concept personal responsibility?
2. When thinking about how someone can show they are taking personal responsibility, do you think these could be broken down into key parts/different categories?
 - For example, do you think there is a distinction between something that is overt and observational and internal experiences?
3. Do you believe it is important for service users to take personal responsibility? Why, why not?
4. How might personal responsibility be linked to progress through secure services/recovery?
5. Do you think personal responsibility can change over time? How can services/professionals aid this?
6. How can a service user show they take personal responsibility in a secure mental health setting?
 - What are the consequences of this?
7. If a service user was not taking personal responsibility, what would this look like?
8. What factors might influence how a service user takes personal responsibility?
 - What might help a service user increase taking personal responsibility?
 - What might cause a service user to take less personal responsibility?
9. Have you encouraged a service user to take personal responsibility before?
10. Have you previous discussed personal responsibility with colleagues at work?

11. Reflecting on what we have discussed, do you think there are any benefits to considering personal responsibility in this setting?

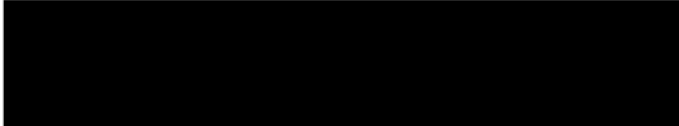
- Do you think there are any challenges?

Appendix D: Focus Group Question Schedule

1. What does the term 'personal responsibility' mean to you?
2. If you broke down the term 'personal responsibility' into key parts, what would these key parts be?
 - Are there different categories to personal responsibility?
3. What in your life do you take personal responsibility for?
4. Is there anything that effects how someone might take personal responsibility?
 - What might help someone in hospital take more personal responsibility?
 - What might cause someone in hospital to take less personal responsibility?
5. Can other people see when someone is taking personal responsibility? What would it look like to somebody else?
6. If someone is not taking personal responsibility, what would this look like?

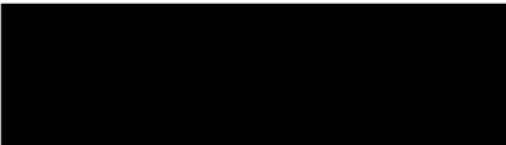
Appendix E: Ethical Approval from University of Birmingham

Application for Ethical Review ERN_18-1777



Reply all | v

Inbox



**Re: "The development of a questionnaire to measure 'personal responsibility' with service users within clinical forensic rehabilitation."
Application for Ethical Review ERN_18-1777**

Thank you for your application for ethical review for the above project, which was reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I confirm that this study now has full ethical approval.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly brought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at <https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx>) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (<https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx>) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

Please be aware that whilst Health and Safety (H&S) issues may be considered during the ethical review process, you are still required to follow the University's guidance on H&S and to ensure that H&S risk assessments have been carried out as appropriate. For further information about this, please contact your School H&S representative or the University's H&S Unit at healthandsafety@contacts.bham.ac.uk.

Kind regards,

Ms Sam Waldron
Deputy Research Ethics Officer
Research Support Group
C Block Dome (room 132)
Aston Webb Building
University of Birmingham
Edgbaston B15 2TT
Tel:
Email:

Web: <https://intranet.birmingham.ac.uk/finance/RSS/Research-Support-Group/Research-Ethics/Research-Integrity-at-the-University-of-Birmingham.aspx>

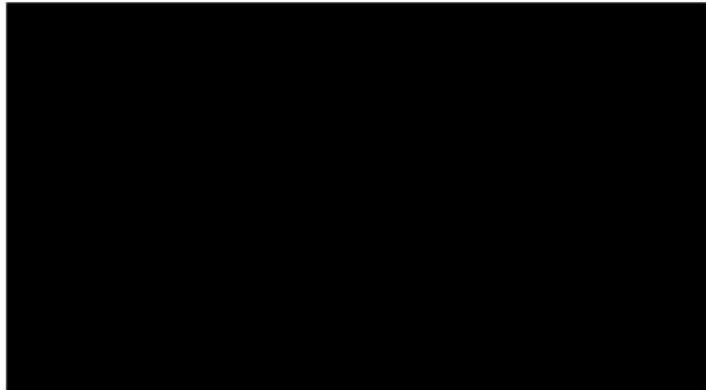
Please remember to submit a new [Self-Assessment Form](#) for each new project. Click [Ethical Review Process](#) for further details regarding the University's Ethical Review process.

Click [Research Governance](#) for further details regarding the University's Research Governance and Clinical Trials Insurance processes, or email researchgovernance@contacts.bham.ac.uk with any queries

Notice of Confidentiality:

The contents of this email may be privileged and are confidential. It may not be disclosed to or used by anyone other than the addressee, nor copied in any way. If received in error please notify the sender and then delete it from your system. Should you communicate with me by email, you consent to the University of Birmingham monitoring and reading any such correspondence.

Appendix F: Ethical Approval from the Research Site



Tuesday 4th June 2019

Dear Sophia

RE: 103_The development of a questionnaire to measure 'personal responsibility' with service users within clinical forensic rehabilitation_

Thank you for sending through evidence that NHS ethics is not required for this project. I am pleased to advise that we are able to give conditional approval for you to conduct your research study at St Andrew's Healthcare, **subject to us receiving evidence of a favourable opinion from the University of Birmingham Ethics Committee.**

The clinical lead for this project is [REDACTED] in regard to the on-site management of the project.

Next steps

1. You will need to secure full ethics approval; please email a copy of the favourable opinion letter to me ([research@\[REDACTED\].co.uk](mailto:research@[REDACTED].co.uk))
2. Once I have evidence of full ethical approval you will be able to commence your project.

Expectations

In relation to research conducted at [REDACTED] you will be required to:

- Update the department on a regular basis
- Comply with any requests related to audits or service evaluation
- Comply with [REDACTED] policies
- Follow Authorship Good Practice, as shown over

Project completion

On completion of your study, we require:

- An executive summary report of the research
- A copy of the final report
- Your [REDACTED] affiliation to be referenced in any publications relating to this research, including journal articles, posters and conference materials. Please use the following wording: [insert title, e.g. Visiting Researcher], [REDACTED]
[REDACTED]

- Updates about dissemination activities; including conference presentations and publications in peer-reviewed journals – please see Authorship Good Practice below
- You may also be invited to present the results of your research to a wider audience within [REDACTED].

Authorship Good practice

It is good practice to discuss and agree the expected roles, contribution and responsibilities, including authorship of all collaborators, at the very start of the research process. This includes the appropriate recognition of any substantial intellectual contribution of members of the [REDACTED] such as:

- Conception or design of the work
- Acquisition, analysis or interpretation of data for the work
- Drafting the work or revising it critically for important intellectual content
- Final approval of the version to be published

Yours sincerely

[REDACTED]

Research Administrator

Copied to:

[REDACTED]

Appendix G: Service User Participant Information Sheet



PARTICIPANT INFORMATION SHEET

Project: Development of a 'Personal Responsibility' Questionnaire

Chief Investigator: Sophia Barford

You are invited to take part in a research study.

Before you decide if you would like to take part, please read this information sheet carefully.

If any information is not clear, or you have questions, please contact Sophia Barford or Dr



Contact details are at the end of this sheet.

What is this study about?

This study will be making a questionnaire to measure 'personal responsibility'.

The study is split into different stages. You are being invited to take part in stage 1 which hopes to find what the words 'personal responsibility' means to you.



What will I do if I take part?

You will be asked to take part in a group chat for about an hour.

There will be about 6 other patients taking part in the group.

There will be 2 or 3 staff members helping to run it. I will ask you to think about the words 'personal responsibility', and then I will ask you to talk about what they mean to you. In the group you will need to keep information confidential.



Do I have to take part?

No. You do not have to do this study. It is your choice.

Taking part, or not, will not change your care or legal rights.



Can I change my mind?

Yes. You can change your mind at any time and leave the group. You do not have to say why you want to stop.

Are there any good things for taking part?

There are no immediate rewards, but your input will help us to get information to help other people. We hope you would enjoy the group discussion. Your opinion will be valued and the questionnaire that will be made from this study is hoped to help clinical teams.

Are there any risk for taking part?

It is not expected that there will be any risks to you.

What happens to my information?

Your information will be kept private and safe.

If you talk about an issue that have serious consequences, like someone being hurt, or if you talk about an offence that is not known about, then this will be discussed with you, and your clinical team would have to be told.



What if there is a problem?

If you are not happy at any time you can tell Sophia Barford, or [REDACTED] You can also ask staff to email them [REDACTED]

[REDACTED].

If you want to complain formally, you can do this too. You can contact [REDACTED]

[REDACTED]

Contact details

Chief Investigator: Sophia Barford, Trainee Psychologist

Email: [REDACTED]

Thank you for Reading the Participant Information Sheet and considering taking part in this research study.

Appendix H: Service User Consent Form



CONSENT FORM

Project: Development of a 'Personal Responsibility' Questionnaire

Chief Investigator: Sophia Barford



Please initial box

1. I have read the information sheet.
I have thought about this and asked any questions I need to.
2. My participation is voluntary and I can withdraw at any time without giving a reason. My care or legal right will not be affected by this.
3. Any personal information will stay confidential, and data will be anonymised so I cannot be identified.
4. If I raise an issue that has serious consequences, like someone being hurt, or if I talk about a previously unknown offence then this will be discussed with me and my clinical team would have to be told.
5. My Responsible Clinician knows I am in this study, and agrees to me taking part. My Responsible Clinician will provide the research team with any required information.
6. I agree to take part in the focus group.



Have you taken part in any other studies? Yes No

Would you like to have a summary of the study when it is finished? Yes No

Name of Participant Date Signature

Name of Person taking consent Date Signature

I WANT TO HEAR FROM YOU

WHAT IS A SERVICE USER'S RESPONSIBILITY?

HOW SHOULD WE THINK ABOUT RESPONSIBILITY IN A SECURE MENTAL HEALTH SETTING?

TAKE PART IN RESEARCH

Personal responsibility might be important in the care and treatment of service users in secure mental health services. We want to know what you think, and what personal responsibility means to you as a staff member working in secure care.

If you are interested in sharing your thoughts and helping with the study, you can [take part in an interview](#).

FOR MORE INFORMATION, PLEASE CONTACT [REDACTED]

Thank you!

Appendix J: Staff Participant Information Sheet




PARTICIPANT INFORMATION SHEET

Project: Staff Perception of Personal Responsibility In Forensic Mental Health Services

Chief Investigator: Sophia Barford

You are invited to take part in a research study.

Before you decide if you would like to take part, please read this information sheet carefully.

If any information is not clear, or you have questions, please contact Sophia Barford or 

Contact details are at the end of this sheet.

What is this study about?

The aim of this study is to understand the construct personal responsibility in a forensic mental health setting.

It is thought that personal responsibility might be important in the care and treatment of service users who have mental health needs or for those with offender treatment needs. Forensic mental health services are unique settings where both can be treatment aims.

What will I do if I take part?

You will be asked to take part in an interview. The interview will take place on the phone and will be recorded.

You will be asked to think about the words 'personal responsibility', and what they mean to you in the context of clinical forensic rehabilitation.

Do I have to take part?

No. You do not have to do this study. It is your choice.

Taking part, or not, will not affect your employment or legal rights.

Can I change my mind?

Yes. If you agree to take part in the study, and then change your mind, you may do so at any time and end the interview. You do not have to give a reason.



Are there any advantages for taking part?

There are no immediate benefits, however we hope you would enjoy the discussion. Your opinion will be valued and the questionnaire that will be made from this study is hoped to help clinical teams.

Are there any disadvantages for taking part?


It is not expected that there will be any risks to you. The main disadvantage anticipated is the time required to participate in the study.

What happens to my information?


Your information will be kept confidential and anonymised.

If you talk about an issue that have serious consequences, like someone being hurt, or if you talk about an offence that is not known about, then this will be discussed with you, and your clinical team would have to be told.

What if there is a problem?

If you are not happy at any time you can contact Sophia Barford, or 



If you want to complain formally, you may contact 

Contact details

Chief Investigator: Sophia Barford, Trainee Psychologist

Email: 

Thank you for reading the Participant Information Sheet and considering taking part in this research study.

Appendix L: Theoretical Position

Theoretical Position

The theoretical position of a researcher comprises the ontological and epistemological assumptions they hold. Ontology refers to the concept of reality, the relationship between the world and human interpretation, whilst epistemology refers to knowledge, how it is obtained and accepted as valid (Braun & Clarke, 2013). Ontological assumptions can be viewed as ranging along a continuum. From realism, in which reality is independent to human perspective, to relativism where reality entirely consists of human interpretation (Tebes, 2005). There are thought to be three epistemological assumptions, positivism, constructionism and contextualism. Positivism states that through objective data collection a valid truth can be established. Whereas constructionism states there is no single truth to be found, but knowledge is how we understand something. Contextualism argues a bridge between the first two (Henwood & Pidgeon, 1994). It assumes an understanding of the truth can be obtained, but it will be related to the context in which it was produced. The stances a researcher holds influences what methodology would be followed, and therefore should be outlined.

Statement of Position

Regarding my ontological assumptions, I hold a critical realist position. This is known to fall between the polar ends of the ontology continuum and holds the view that there is a real world that 'sits behind' subjective knowledge (Braun & Clarke, 2013). I believe that finding elements of truth is required to make impactful change in my role as a Trainee Forensic Clinical Psychologist. For example, building an evidence base for therapeutic intervention requires some recognition of psychological constructs existing. However, I acknowledge that it may not be possible to remove the researcher from any attempt to

captured knowledge. This aligns with the contextualism epistemological assumptions I also hold. This is that I believe a 'truth' can be obtained, but that it could not sit separate to the context in which it is sought and understood.

The current study sought to explore participant's understanding of personal responsibility, with each participant presenting a subjective depiction of the construct based on their experiences. However, the construct has been presented across multiple paradigms and fields of literature, which I interpret as being grounded in the ability to capture a 'truth'. This reflects my theoretical position by the current research presenting one picture of how personal responsibility is understood in forensic mental health settings.

References

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