12 Hallam A, Beecham J, Knapp M, Carpenter J, Cambridge P, Forrester-Jones R, et al. Service use and costs of support 12 years after leaving hospital. *J Appl Res Intellect Disabil* 2006; **19**: 296–308.

13 Pirkis JE, Burgess PM, Kirk PK, Dodson S, Coombs TJ, Williamson MK. A review of the psychometric properties of the Health of the Nation Outcome Scales (HoNOS) family of measures. *Health Qual Life Outcomes* 2005; **3**: 76.

14 Department of Health. *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs. 'The Mansell Report II'*. TSO (The Stationery Office), 2007 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_080128.pdf).

15 Bhaumik S, Gangadharan SK, Devapriam J. Payment by Results: The Way Ahead. *Learn Disabil Psychiatry* 2008; **10**: 8 (http://www.rcpsych.ac.uk/pdf/ldp10_2.pdf).

The recovery approach to care in psychiatric services: staff attitudes before and after training

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Aims and method To investigate the attitude of staff towards the recovery approach in forensic mental health services and the impact of training on staff knowledge and attitudes. A specially constructed 50-item recovery approach staff questionnaire, which focused on the core components of the recovery approach, was completed by 137 members of staff in in-patient forensic services in Lambeth, south London.

Results Staff were generally very positive about the implementation of the recovery approach in forensic services and those who had received training scored significantly higher on the questionnaire than non-trained staff.

Clinical implications The great majority of staff agree that the recovery approach to care does have a place in forensic services. This is important and needs to be built into the implementation of this approach in forensic services.

Declaration of interest None.

Recovery approaches to care promote a 'new clinical philosophy',[1] which encourages movement away from the traditional medical approach to treatment of mental illness and towards a more person-centred and humanitarian approach, viewing patients as 'experts by experience'.[2] The recovery approach is more personalised and subjective, and service users are encouraged to redefine their role, from passive suppliers of opinion towards active negotiators in the process of change.[3] Staff and service provider attitudes are noted to be a key determinant in the provision of recovery-oriented care.[4]

In order for recovery approaches to care to be implemented into clinical services, an attitude shift by service providers is required to understand the factors that influence recovery.[5] It is recognised that 'training clinicians is essential because recovery-focused care requires new attitudes and skills'.[6] To implement recovery-oriented practice within mental health services, staff training needs to incorporate the lived experience of service users.[7] Preliminary evidence from Australia indicates that recovery-training programmes can improve staff attitudes towards recovery and significantly increase staff knowledge regarding recovery principles.[8] Specifically, such training programmes can aid mental health professionals in understanding principles of recovery and collaboration and in supporting service user autonomy.

Within the UK, the South London and Maudsley National Health Service (NHS) Foundation Trust is actively promoting recovery approaches to care into practice,[9] as well as training for mental health professionals, including the forensic services. Evaluation of the success of one training programme within the Trust has been completed.[10] Slade and colleagues[10] aimed at piloting methods for evaluating the impact of recovery-training programmes for mental health service staff. They report that there is no recovery outcome measure with UK norms available and found that outcome data were not of high value. The measures that were available were 'not of high clinical relevance' and staff whom Slade and colleagues interviewed appeared to have difficulty relating the questionnaires to their work. Therefore, a measure with clinical relevance, focusing on the importance of personalised care, is needed in order to properly assess the effect of training on staff knowledge and attitudes and to measure the general attitudes of staff towards the recovery approach irrespective of whether or not they are trained in this 'new philosophy'.

The present study reports on the development and implementation of such a measure. We investigated the knowledge of staff working within in-patient forensic mental health services about recovery approaches to care and how training influenced their knowledge and attitudes. The main hypotheses being tested were that

staff are generally positive about the implementation of recovery approaches in forensic services and that participation in a within-service training programme on such an approach will improve staff knowledge and generate even more positive attitudes towards recovery-oriented practice.

Method

Participants

Overall, 150 staff completed a specially designed recovery approach questionnaire (see online supplement to this paper, Appendix 1); 77 completed it in 2007 (51.3%) and 73 in 2008 (48.7%), of whom 13 had also completed it in 2007 (8.7%) – they were excluded from the study, which left 137 participants. There were 71 males (53%) and 64 females (47%) (2 participants had not given their gender). Of the 127 participants who gave their ethnic background, 60 were Caucasian/White (47%) and 67 were Black and minority ethnic (53%). Of the 67 participants in the Black and minority ethnic group, 30 were Caribbean (45%), 24 African (36%), 7 Asian (10%) and 6 were from other (unspecified) ethnic backgrounds (9%). For those who indicated their profession ($n = 133$), 82 were nurses (62%), 8 psychologists (6%), 7 psychiatrists (5%), 7 occupational therapists (5%), 6 social workers (5%), and 23 were from other groups such as nursing assistants and support workers (17%).

Measure

The recovery approach staff questionnaire is a structured self-report measure consisting of 50 closed questions probing the individual's knowledge and understanding of the principles of the recovery approach and social inclusion (online supplement, Appendix 1). The questionnaire was developed by the Southwark Recovery Approach Implementation Group, which included an ex-service user. Existing staff questionnaires were considered too lengthy and not suitable for the recovery approach being applied in forensic settings.

The questionnaire was specifically developed for application in forensic services, but the content was guided by published work on the recovery approach,[4,7,11] where the focus is on teaching and training service users to be instrumental in their own care and recovery (i.e. learning to do things for themselves through collaboration with others, rather than being passive recipients of care), developing hope, and staff facilitating realistic choices and opportunities. It is also important for staff to understand that the recovery approach principles can be applied before or jointly with individual and group therapy programmes, including medication (i.e. the recovery approach commences at the point of in-patient admission), that they do not replace medication or psychological treatment programmes, and that it does not mean that service users become symptom-free or that relapses do not occur. The basic assumption was that the recovery approach is applicable to forensic practice, including service users with mental illness, personality disorder and intellectual disabilities, although it is notable that there are no published data on the recovery approach with these forensic services.

We also collected basic participant information such as gender, age, ethnicity, occupation, occupational setting and the number of years a person had worked with forensic patients.

Apart from item 2 ('I have attended a training course on the recovery approach to care', which was rated either as 'true' or 'false' and was the key predictor in the research), the remaining 49 items were rated on a three-point scale: true (3), not sure (2) and false (1). The scoring was reversed for items that should be endorsed in the negative: false (3), not sure (2) and true (1). The maximum score for the 49 questions was 147 (range 49–147).

Forensic recovery approach staff training programme

The importance of providing mental health professionals, particularly nursing staff, with training in the recovery approach has been identified and a number of training packages have been developed.[10,11] Training for staff in medium secure units within forensic services in Lambeth was devised in a number of stages, one of which was a 1-day training package on the forensic recovery approach to care. The aims of the training were to:

- introduce staff to the recovery approach
- help staff explore what recovery means to them
- educate staff about the recovery approach within forensic services
- enable staff to learn how to apply the recovery approach in their work
- enable staff to practise working with clients (role-play) using a recovery-oriented approach.

Facilitators were experts by professional experience in recovery and the training day contained a balance of didactic teaching and experiential learning through role-play. All attendees were given a handbook, which provided them with materials they could use to implement recovery-oriented practice (for the training programme schedule, see online supplement, Appendix 2).

Procedure

In the summer of 2007 and spring 2008, all ward staff were circulated the questionnaire and asked to complete it. Nursing team leaders for each of the wards were asked to encourage their staff to participate. Staff were fully informed of the research aims and were made aware that their responses would be anonymous and confidential.

Ethical approval for the audit was sought from the Clinical Governance Department of the South London and Maudsley NHS Foundation Trust.

Results

Out of the 137 participants, 47 reported having attended recovery-approach training (34%): 14 of those who completed the questionnaire in 2007 (18%) and 33 in 2008 (55%).

Alpha reliability analysis was performed on the 49 questionnaire items to determine the internal consistency of the measure (item 2 was left out since this was the 'fixed' outcome variable). The Cronbach's α reliability coefficient

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Table 1 Significant differences between those who had and those who had not received training on the recovery approaches, as shown on the study questionnaire

Explanatory variable	Received training *n* (%)	Not received training *n* (%)	χ^2	Odds ratio (η)
I am familiar with the principles of the recovery approaches to care[a]	42 (89.4)	51 (56.7)	11.14***	6.4 (0.332)
I would like to learn more about the recovery approaches to care[a]	38 (80.9)	87 (96.7)	−9.66**	0.146 (0.266)
The recovery approaches to care mean that patients will become more dissatisfied with their stay in hospital[b]	35 (74.5)	49 (54.4)	5.22*	2.43 (0.195)
Recovery means people become symptom-free[b]	44 (93.6)	62 (68.9)	10.78***	6.62 (0.281)
People in recovery do not use medications or other forms of psychiatric treatment[b,c]	47 (100)	78 (86.7)	5.30*	(0.224)
Recovery means no relapses or significant setbacks will occur[b]	44 (93.6)	73 (81.1)	3.87*	3.4 (0.168)
Recovery is about patients no longer needing professional help[b]	46 (97.9)	74 (82.2)	6.70**	9.9 (0.225)
The recovery approaches to care mean that there is going to be greater risk to the public[b]	42 (89.4)	67 (74.4)	4.22*	2.9 (0.176)
Recovery is only for individuals, not for families, teams, organisations[b]	43 (91.5)	68 (75.6)	5.10*	3.5 (0.193)
Focusing on the patients' goals, expectations and beliefs has no place in the recovery approaches to care[b,c]	47 (100)	77 (85.6)	5.91*	(0.234)
Patients rarely have anything useful to say about their treatment[b]	46 (97.9)	78 (86.7)	4.51*	7.1 (0.182)
The recovery approaches to care are not suitable for forensic patients[b]	46 (97.9)	77 (84.4)	5.71*	8.5 (0.204)
If recovery approaches take hold, there will be no need for mental health workers[b,c]	47 (100)	80 (88.9)	4.11*	(0.203)
Learning and integrating recovery principles into my clinical practice means that what I learnt in my professional training is obsolete[b]	45 (95.7)	71 (78.9)	6.76*	6.2 (0.222)
The recovery approaches to care can make some patients more difficult to manage[d]	30 (63.8)	40 (44.4)	4.64*	2.2 (0.184)
Treatment of the illness has to come before recovery principles can be employed[b]	34 (72.3)	38 (42.2)	11.23***	3.6 (0.286)
The recovery approaches to care are not going to work for patients who are detained compulsorily in hospital[b]	44 (93.6)	65 (72.2)	8.69**	5.6 (0.252)
The recovery approaches to care mean that patients can be discharged more quickly into the community[b]	16 (34.0)	16 (17.8)	4.56*	2.4 (0.182)
The recovery approaches to care are not likely to work for in-patients[b]	45 (95.7)	67 (74.4)	9.39**	7.8 (0.262)
The recovery approaches to care have no place in forensic services[b]	46 (97.9)	76 (84.4)	5.71*	8.5 (0.204)
Recovery approaches can only be employed in a community based care setting[b]	43 (91.5)	68 (75.6)	5.10*	3.5 (0.193)
Patients with a diagnosis of personality disorder cannot be treated using recovery approaches to care[b]	37 (78.7)	50 (55.6)	5.60*	7.15 (0.228)
Patients with intellectual impairment are not suitable for using recovery approaches to care[b]	38 (80.9)	55 (61.1)	5.53*	2.7 (0.201)

*$P<0.05$; **$P<0.01$; ***$P<0.001$.
a. True.
b. False.
c. No odds ratio provided as the expected frequency for one of the cells was <1 (Yates continuity correction applied).
d. False/not sure.

for the scale was 0.81, indicating a highly internally consistent scale.

The mean total score for the 137 participants was 129.91 (s.d. = 10.81, range 92–145). The mean score for those who had received training ($n = 47$) was 133 in contrast to 128 for those who had not received training ($n = 90$). The difference between the two groups is significant ($t = 3.5$, $P < 0.01$). However, staff were generally very positive in their attitude towards the recovery approach. Even those who had not been trained in this new philosophy were positive, which is reflected in the overall high score among both groups.

The average number of years in forensic practice was 6.3 (s.d. = 6.2, range 1 month to 27 years). There was no significant correlation found between length of forensic practice and the total score ($r = 0.07$).

A significant difference (α set at 0.05) was noted on 23 of the items (46.9%) between those who had attended training and those who had not (Table 1). As expected, the

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training had a significant effect on a number of items, including staff reporting greater familiarity with the principles of the recovery model, believing that recovery does not mean that the service user becomes symptom-free or that treatment has to commence before the recovery approach can be applied. Another important finding was that after training almost all staff (96%) believed that the recovery approach was going to work with patients who were detained compulsorily in hospital, although greater uncertainties were reported with regard to service users with personality disorder (79%) or those with intellectual disabilities (81%). Greatest uncertainty was found in relation to whether or not applying the recovery approach meant that patients would be discharged more quickly into the community (34% believed that this was not the case).

Discussion

The key components to the recovery approach are factors that facilitate hope, opportunities and a sense of control in service users.[4] Hope is the motivating force that gives people a sense of purpose, direction in life, and enables them to pursue their aspirations. Recovery is about service users being able to do the things that give their lives a meaning and purpose. It is not merely about relieving symptoms and discharges from services. Services need to provide users with opportunities for reaching their goals. This means that healthcare workers need to gain insight into service users' experiences, perspectives and aspirations, make them feel valued, and provide them with opportunities and treatment choices.

The philosophy behind such an approach to care can be easily incorporated into existing treatment programmes in forensic services[12] and may improve patients' attitudes towards their care and motivation to engage in treatment.[13] Mental health workers need to accept and value service users, identify their strengths and interests, and build up their confidence and self-efficacy.

Employing staff with recovery knowledge, skills, qualities and capabilities has been identified as a key theme in recovery-based practice.[9] Our findings show that the majority of both those who had received training (98%) and those who had not (84%) were generally very positive about the recovery approach to care and its implementation in forensic services. This encouraging finding needs to be built into the implementation of the recovery approach across in-patient forensic services.

Our study also shows that staff training programmes can be a way for mental health services to foster recovery-oriented practice, although some caution needs to be exercised with regard to the interpretation of this study due to methodological limitations. For example, it is possible that there was some bias towards the recovery approach in staff who had done the training, and the differences may not entirely reflect the effects of training (ideally this would need to be measured by comparing responses before and after training, which was not done here).

The fundamental issue for forensic services regarding the choice agenda is to manage the tension between caring for patients while protecting them and society from harm, a tension which can be managed by incorporating patients' values in decision-making and giving patients the necessary high-quality information to allow them to make informed decisions about their care.[14] Although forensic services may be presented with a particular challenge with regard to incorporating some of the principles of recovery approaches to care, particularly those concerned with increasing choice and control for patients, a central and greatly valued support to the recovery process is in mental health professionals finding ways to convey optimism.[15] These are skills which mental health professionals can employ regardless of the nature of their clients' offences.

Finally, a prospective study is needed before it can be accepted that the recovery approach to care offers a distinct therapeutic advantage over current practice. We have received ethical approval for such a study, which has now commenced.

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References

1 Roberts G, Wolfson P. The rediscovery of recovery: open to all. *Adv Psychiatr Treat* 2004; **10**: 37–48.

2 Department of Health. *The Journey to Recovery: The Government's Vision for Mental Health Care*. Department of Health, 2001.

3 Pilgrim D, Waldron L. User involvement in mental health service development: how far can it go? *J Ment Health* 1998; **7**: 95–104.

4 Repper J, Perkins R. *Social Inclusion and Recovery: An Approach for Mental Health Practice*. Balliere-Tindall, 2003.

5 Rickwood D. Recovery in Australia: slowly but surely. *J Adv Ment Health* 2004; **3**: 1–3.

6 Torrey WC, Wyzik MA. The recovery vision as a service improvement guide for community mental health center providers. *Community Ment Health J* 2000; **6**: 209–16.

7 British Psychological Society. *Understanding Mental Illness: Recent Advances in Understanding Mental Illness and Psychotic Experiences*. BPS, 2000.

8 Crowe T, Deane F, Oades L, Caputi P, Morland K. Effectiveness of a collaborative recovery training program in Australia in promoting positive views about recovery. *Psychiatr Serv* 2006; **57**: 1497–1500.

9 Care Services Improvement Partnership, Royal College of Psychiatrists, Social Care Institute for Excellence. *A Common Purpose: Recovery in Future Mental Health Services. Joint Position Paper 08*. SCIE, 2007.

10 Slade M, Luke G, Knowles L. Methodologies for evaluating recovery training. *Clin Psychol Forum* 2009; **193**: 10–5.

11 National Institute for Mental Health in England. *NIMHE Guiding Statement on Recovery*. Department of Health, 2005.

11 Gudjonsson GH, Young S. The role and scope of forensic clinical psychology in secure unit provisions. A proposed service approach for psychological therapies. *J Forens Psychiatry Psychol* 2007; **18**: 534–56.

12 Gudjonsson GH, Young S, Yates M. Motivating mentally disordered offenders to change. Instruments for measuring patients' perception and motivation. *J Forens Psychiatry Psychol* 2007; **18**: 74–89.

13 Hope T. Evidence-based patient choice and psychiatry. *Evid Based Ment Health* 2002; **5**: 100–1.

14 Borg M, Kristiansen K. Recovery-oriented professionals: helping relationships in mental health services. *J Ment Health* 2004; **13**: 493–505.

https://doi.org/10.1192/pb.bp.109.028076 Published online by Cambridge University Press