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A Qualitative Study of Recovery-Oriented Services in Inpatient Forensic Settings

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A QUALITATIVE STUDY OF RECOVERY-ORIENTED SERVICES IN INPATIENT FORENSIC SETTINGS

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Dissertation Approval

This is to certify that the thesis presented to us by Deanna Pecora on the 2nd day of November, 2012, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Abstract

Recovery principles are currently guiding the transformation of mental health practice and policy in the United States (Anthony, 2000; Davidson et al., 2005; Davidson et al., 2006; Ralph & Corrigan, 2007). Although principles of recovery have become the focus of mental health care reform, they have just begun to enter the forensic system (Hillbrand & Young, 2008). This is important because the forensic state hospital population has experienced a significant growth, reportedly approximating 50 % of all beds in given states, while the general civil state hospital population continues to decline (Salzer et al., 2006). Furthermore, Hillbrand and Young (2008) suggest that instilling hope is an essential treatment goal in forensic settings. The purpose of this study is to provide qualitative and survey research designed to examine and operationalize how recovery-oriented services have been implemented by program directors and staff as well as the challenges that may exist in forensic settings.

Table of Contents

Chapter One: Introduction

Statement of the Problem

During the past decade, with the Surgeon General's Report on Mental Health and the publication of the President's New Freedom Commission on Mental Health's Final Report, *Achieving the Promise: Transforming Mental health Care in America* (DHHS, 2003), recovery principles have been guiding the transformation of mental health practice and policy (Anthony, 2000; Davidson et al., 2005; Davidson et al., 2006; Ralph & Corrigan, 2007). Recovery is a complex construct that is difficult to operationalize (Davidson et al., 2005; Jacobson, 2001; Ralph & Corrigan, 2007). Both internal and external conditions that facilitate recovery have been identified (Jacobson & Greenley, 2001). The internal conditions include hope, healing, empowerment, and connection. The external conditions include human rights, a positive culture of healing, and recovery oriented services. The internal and external factors that facilitate recovery are reciprocal and this process, therefore, can become a condition that further aids recovery.

During this time of transformation, there has been an emergent emphasis on exploring mental health service delivery to ensure that services reflect the abovementioned components of recovery (Salyers et al., 2007). Anthony (2000) suggests that recovery oriented services should include treatment to reduce symptoms, crisis intervention, case management, rehabilitation, enrichment which involves fulfilling activities, rights protection advocacy, basic support such as food and housing, self-help, as well as wellness and prevention. Furthermore, several mental health agencies have begun to address the importance of implementation of recovery oriented services in the mental health system; these include the National Alliance for the Mentally Ill's *Omnibus*

Mental Illness Recovery Act: a Blueprint for Recovery and the Substance Abuse and Mental Health Association's *Recovery to Practice* project.

Although principles of recovery have become the focus of mental health care reform in the United States, recovery principles have just begun to enter the forensic system (Hillbrand & Young, 2008). This is important because the forensic state hospital population has experienced a significant growth, reportedly approximating 50 % of all beds in given states, but the general, civil state hospital population continues to decline (Salzer et al., 2006).

Appropriate treatment of individuals with mental illnesses is critical not only to maintain safety in forensic settings, but also to successfully integrate patients back into the community and to reduce rates of recidivism (Berzins & Trestman, 2004). Furthermore, Hillbrand and Young (2008) suggest that instilling hope while managing anger associated with despair and desperation often experienced by inmates is an essential treatment goal in forensic settings.

Little research is found regarding the implementation of recovery principles and recovery-oriented services in forensic settings. Implementation of recovery-oriented services may be especially challenging in a forensic setting due to the unique barriers and legal mandates of the forensic system. Further research is needed to explore the unique challenges and barriers to a transformation of service delivery in forensic settings.

Purpose of the Study

The purpose of this study is to provide qualitative and survey research regarding the implementation of recovery-oriented services in inpatient forensic settings. Specifically, the current study is designed to examine and operationalize how recovery-

oriented services have been implemented by program directors and staff members in inpatient forensic settings. The study will also seek to describe facilitating conditions that enabled recovery strategy implementation, the specific strategies used to implement principles of recovery oriented care, problems, challenges, and/or barriers in applying recovery-oriented services in forensic settings.

Chapter 2: Review of the Literature

Traditionally, many professionals viewed mental illness as a medical illness. In this framework, a mental illness should be carefully diagnosed, with treatment targeting the reduction of symptoms and disabilities to produce recovery (Ralph & Corrigan, 2007). However, in the 1970s, the recovery movement began in the United States when small groups of ex-consumers hoped to bring about change to the mental health system (Schiff, 2004). Recovery is a complex construct that is difficult to operationalize (Davidson et al., 2005; Jacobson, 2001; Ralph & Corrigan, 2007). Literature indicates that current confusion and debate remain in the mental health field when attempting to define the construct of recovery. In part, recovery is difficult to define because of two divergent ways in which recovery is described: outcome vs. process (Ralph & Corrigan, 2007; Davidson et al., 2005; Davidson & Roe, 2007).

Recovery as an Outcome: Recovery from Mental Illness

Emil Kraeplin, the father of modern psychopathology, endorsed the belief that mental illness, specifically schizophrenia, is a degenerative and progressive disease that does not respond to treatment (Ralph & Corrigan, 2007; Davidson & Roe, 2007). Kraeplin's beliefs were supported in the psychiatric field for over 50 years. However, in 1967, The World Health Organization initiated the International Pilot Study of Schizophrenia and a series of longitudinal studies that found 25 to 65 percent of each population experienced a partial to full recovery (Davidson et al., 2005; Davidson & Roe, 2007). These results indicated that individuals do indeed recover from the symptoms of mental illness (some without the aid of mental health services), and highlighted as well that Kraeplin's pessimistic beliefs accounted for about only 25 % of each sample.

Furthermore, Harding (1988) compared and contrasted three studies conducted in the United States and Europe that looked at illness trajectories of individuals with Schizophrenia. These studies also dispelled the belief that individuals were predestined to live with their mental illnesses for the rest of their lives. In the Harding studies, that looked at a 20 to 30 year follow-up period, a rule of thirds emerged: one-third of the sample experienced a "normal" life without the mental health system; one-third achieved life's goals and symptom reduction with the help of the mental health system, and one-third of the sample experienced continued periods of significant symptoms as well as periods of remission. Again, this research challenged the field's view that a major mental illness such as Schizophrenia follows a degenerative course that is unresponsive to treatment and it provided an empirical basis for recovery (Schiff, 2004).

These studies support the hypothesis that people with a mental illness can achieve their life goals and improve their quality of life (Schiff, 2004). In fact, one-quarter to two-thirds of individuals will attain this form of recovery, a prognosis very different from any previously endorsed (Davidson & Roe, 2007). It is important to note that recovery in this framework refers to an improvement of symptoms to the degree that daily functioning, which includes personal, social, and vocational activities are within a "normal" range (Davidson et al., 2005; Davidson & Roe, 2007; Ralph & Corrigan, 2007).

Recovery as outcome: Mental illness as a medical illness. According to Ralph & Corrigan (2007), a sizeable portion of professionals view mental illness as a medical disorder. In this paradigm, individuals with mental illness are diagnosed and receive a corresponding treatment plan to reduce symptoms and deficits. Symptom and deficit reduction as a result of treatment will then lead to psychological well-being and

achievement of life goals, all of which are hallmarks of recovery. Tower (1994) suggests the medical model defines mental illness as impairment, with the locus of the problem residing within the "patient". Furthermore, mental health professionals control the method of recovery with the primary goals of safety, employment, and maximum functioning. Again, in this model, recovery is measured in terms of the outcome of treatment such as a symptom reduction or a disability-free end point (Ralph& Corrigan, 2007).

Recovery as a Process; The Consumer-Survivor Movement: Recovery in Mental Illness

The historically pessimistic views of mental illness endorsed by the mental health field unintentionally removed hope from individuals with serious mental illness (Ralph & Corrigan, 2007). The medical treatment model furthermore postulated that symptom reduction or a return to baseline functioning was a necessary condition for individuals in order to return to meaningful participation in community life. A different meaning of recovery was initiated by the consumer-survivor movement that defined recovery as a process that did not require the reduction of symptoms or a disability-free end point to maintain basic civil rights such as making personal choices, pursuing individual hopes and goals, establishing gainful employment, to choosing and participating in activities that are personally meaningful (Davidson et al., 2005; Ralph & Corrigan, 2007; Davidson et al., 2006). Consumer-survivors had several common goals including the need to change the practice of involuntary hospitalization and improve access to employment, housing, benefits, mental health services, and self-help, as well as reduce experiences of discrimination (Frese & Davis, 1997). Consumer-survivors also changed the traditional

language of "patient" to consumer (Schiff, 2004). In this paradigm, recovery focuses on actions and environmental factors that support a meaningful life for individuals with mental illnesses. A mental illness is viewed as one component of the whole person and the individual is not expected to be symptom free to have hope in leading a meaningful quality life (Davidson et al., 2005).

Throughout history, consumer-survivors have been speaking about their experiences with mental illness and advocating for their rights (Frese & Davis, 1997; Schiff, 2004). Dating back to the end of the Civil War, Elizabeth Packard founded the Anti-Insane Asylum Society, and Clifford Beers wrote "A Mind That Found Itself" (Frese & Davis, 1997). Both Elizabeth Packard and Clifford Beers were speaking out about the horrific treatment they had experienced as mental health consumers. The modern consumer-survivor movement began in the early 1970s without the awareness of the previous historical efforts (Frese & Davis, 1997; Schiff, 2004).

Not only was the recovery movement given impetus through consumer-survivor, first-hand accounts of mistreatment, but it was also cultivated from several social political movements including the civil rights movement and legislation, demedicalization as well as a move to self-care, deinstitutionalization, and the physical disability independent living movement (Tower, 1994). Individuals that were former consumers of the mental health system began to recognize that they were being denied basic rights as and also being subject to devaluing language and stigma (Frese & Davis, 1997). Feelings of mistrust and anger toward service providers were widespread and small groups began to gather with the hope of bringing change to the mental health system (Frese & Davis, 1997; Schiff, 2004). Some of the early groups included the

Insane Liberation Front, Mental Patients' Liberation, and the Conference on Human Rights and Psychiatric Oppression (Frese & Davis, 1997). In 1976, the President's Commission on Mental Health was created and acknowledged the consumer groups that were being established all over the United States. Diagnosis-specific groups were being created such as the National Depressive and Manic Depressive Associations. The National Alliance for the Mentally Ill, established in 1979, was created by the families of individuals with mental illness. In addition, the Center for Mental health Services was established and continues to be a primary support for the consumer-survivor movement.

In the 1980s**,** the recovery movement emerged from this consumer-survivor movement, in tandem with activists for the physical disabilities (Resnick & Rosenheck, 2006). Although many consumers approve of non-consumers' involvement in the movement, radical consumers advocate for only the consumer perspective. The recovery movement involves consumers, providers, and politicians, as well as policy makers. .

Constructs of Recovery

There are both internal and external conditions that facilitate recovery (Jacobson & Greenley, 2001). The internal conditions include hope, healing, empowerment, and connection. The external conditions include human rights, a positive culture of healing, and recovery-oriented services. The internal and external factors that facilitate recovery are reciprocal, and this process can become a condition that further aids recovery. Additionally, the Substance Abuse and Mental Health Association (SAMHSA, n.d.) suggests 12 guiding principles that further capture the essence of recovery.

- "There are many pathways to recovery.
- Recovery is self-directed and empowering.

- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery is supported by peers and allies.
- Recovery emerges from hope and gratitude.
- Recovery involves a process of healing and self-redefinition.
- Recovery involves addressing discrimination and transcending shame and stigma.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is a reality. It can, will, and does happen."

Internal Constructs in Recovery: Hope, Self-determination, Empowerment, and Connection

Hope. As discussed previously, the views of the mental health field unintentionally removed hope from the diagnosis of serious mental illness (Ralph & Corrigan, 2007). The recovery movement, however, offers hope to individuals with mental illness (Jacobson & Greenley, 2001; Frese & Davis, 1997; Ralph & Corrigan, 2007). Jacobson and Greenley (2001) suggest that hope is an attitude that identifies and accepts that a problem exists as well as the belief that recovery is achievable. The attitudinal component of hope endures even in times of relapse, colors every perceptual experience, focuses on strengths, and celebrates small achievements. The sources that inspire hope, such as God or nature, vary for every individual.

Hope can also be defined as the expectation of achieving a goal (Hillbrand & Young, 2008). It is a feeling that individuals experience when they see a way to a better

future (Singh & Tosh, 2005). Hope is not unrealistic but acknowledges the challenges and pitfalls along the path to recovery. Hope is empathy and respect for an individual's life and potential capacity (Spaniol, 2008). It can appear defiant under extreme circumstances and allow persons to live life on their terms (Singh & Tosh, 2005).

Self-determination. Jacobson and Greenley (2001) also suggest healing is an important component of recovery and emphasizes the process in recovery rather than a symptom-free recovery from mental illness. Mental illness does not define the individual and is considered only a part of the whole person. The challenge here is to overcome the stigma of mental illness and create a sense of self that is broader than the mental illness alone.

Control and self-determination are central themes in recovery and facilitate this healing component of recovery (Jacobson & Greenley, 2001; Frese & Davis, 1997; Schiff, 2004; Tower, 1994; Davidson et al., 2006). Fundamentally, these issues stress an individual's civil rights (Davidson et al., 2006). Individuals with mental illness, as with every other person, have the right to implement personal choice, control their own lives, take an active role in treatment, and pursue their dreams as well as attain their aspirations (Jacobson & Greenely, 2001; Davidson et al., 2006; Schiff, 2004). Davidson et al. (2006) suggest that it is unreasonable and unethical to require individuals with serious mental illness to be symptom-free in order to exercise this right. This right is to be taken away only if there is a clear basis grounded in law and controlled by the criminal justice system (Frese & Davis, 1997; Davidson et al., 2006). Self-determination in recovery in this sense elevates individuals' control over their own lives and emphasizes the fact that consumers have important knowledge regarding their needs and interests, that are equally

if not more important than that of the professionals (Tower, 1994). For instance, this may include a consumer's choosing the best course to address his or her illness as opposed to being prescribed a treatment plan to follow (Jacobson & Greenley, 2001).

Empowerment. Empowerment can be viewed as a corrective process to remedy the lack of choice and self-determination prevalent in the traditional patriarchal mental health service system (McLean, 1995; Jacobson & Greenley, 2001). Empowerment involves individuals acting upon their right to self-determination and experiencing the consequences of those choices. Jacobson & Greenley (2001) suggests empowerment has three components including autonomy, courage, and responsibility. Furthermore, empowerment activities encompass personal and political processes at an individual, group, and societal level (McLean, 1995). For instance, empowerment at an individual level entails activities that improve personal circumstances and increase self-efficacy. Empowerment at a group level involves activities such as advocating for programs needed within the community. Empowerment at a societal level includes advocacy to change laws and policies to improve circumstances such as discriminatory practices and disabling material conditions.

Connection. Recovery is a social process, and connection to others is an important aspect in attaining the other internal aspects of recovery. Connection to others may include activities, employment, relationship with friends or significant other, and advocacy. In many ways, connection involves the larger society offering hope, support, and encouragement to facilitate the connections that individuals with mental illness are attempting to attain (Frese & Davis, 1997). Furthermore, connection links the internal

and external factors of recovery and permits a reciprocal relationship between both components.

External Constructs in Recovery: Human Rights, Supportive Environment, and Recovery Oriented Services

Human rights. Individuals with mental illness have been routinely deprived of basic civil rights including self-determination, inclusion, power, and stigma-free living (Davidson et al., 2006; Rissmiller & Rissmiller, 2006; Schiff, 2004). Advocating and protecting the human rights of individuals with mental illness is a primary component of recovery (Davidson et al., 2006; Jacobson & Greenley, 2001). Schiff (2004) suggests that the recovery movement has always been a political movement and is rooted in the promotion of the rights of people with mental illness. Eliminating stigma, discrimination, involuntary hospitalization, and treatment as well as the promotion of equal opportunity for education, employment, living and access to resources are some areas civil rights advocates focus their attention.

Supportive environment. The process of recovery is not a solitary journey (Frese & Davis, 1997). One of the primary components of recovery is the presence of people who believe, support, and encourage the primary principles of recovery including hope and self-determination (Frese & Davis, 1997; Jacobson & Greenley, 2001; Davidson et al., 2006). Some key elements of a supportive environment consist of support from one's community, from providers, role models, family, and friends (Davidson et al., 2006).

Recovery-oriented services. Recovery-oriented services are collaborative and should be offered by and for consumers, professionals, and family members (Jacobson &

Greenley, 2001). Recovery-oriented services function with the attitude that recovery is possible. Professionals encourage the principles of recovery, particularly self-determination (Frese & Davis, 1997).

Recovery: Consumer Perspectives

The experience of recovery may be different for many consumers; thus, it is difficult to identify essential principles that will apply to all (Davidson et al., 2007). However, there have been several research efforts that reviewed first-person accounts and articles in qualitative literature that have identified common ingredients of recovery from a consumer perspective. There are several common themes that were identified by consumers as important components of recovery.

Hope. Hope is imperative to recovery according to many consumers (Ralph, 2007; Davidson et al., 2007; Schiff, 2004; Young et al., 2003). Hope can be considered a renewal or awakening from despair (Ralph, 2007; Davidson et al., 2007). Hope means finding meaning and purpose in the future (Davidson et al., 2007). Hope is found in many different ways. When identifying what helped consumers foster hope in recovery, many consumers recognized one individual that believed in them (Bassman, 2001), the support of family, employment, and learning from other recovering individuals (Ralph, 2007).

Acceptance and redefining sense of self. Young et al., (2003) found that the process of recovery for many consumers began with overcoming "stuckness," and acknowledging or accepting illness. This does not mean accepting a particular framework, role, or idea about illness but how one understands this as one of life's challenges (Davidson et al., 2007). This may mean accepting help from others (Young et

al., 2003). Schiff (2004) describes recovery as knowing and being able to be who you are without being afraid.

Empowerment. The process of recovery means moving from withdrawal to taking responsibility and becoming an active participant in one's own life (Ralph, 2007; Davidson et al., 2007; Young et al., 2003). Shedding the perceptions of victimization (Young et al., 2003; Davidson et al., 2007) and reframing the belief of being a patient with mental illness to being an individual in recovery (Davidson et al., 2007). Participation includes exercising citizenship through restoration of rights and responsibilities of community living such as working, paying taxes, voting, and engaging in civic activities.

However, overcoming the challenges of mental illness can be extremely difficult because it also involves overcoming social consequences as well as stigma (Davidson et al., 2007). Oftentimes, the community's ideas regarding mental illness and the impact of stigma become internalized by the individual that lives with mental illness. Empowerment in recovery requires the resiliency to fight actively against stigma.

Empowered consumers often speak out through personal experiences to reclaim ownership of their experiences, and they utilize self-help as well as consumer run groups to contribute skills and abilities to the community (Bassman, 2001). Moreover, choice, hope, and possibilities rather than coercion facilitate recovery and empowerment. Consumers may feel suspicious of people who offer help because of experiences of loss of rights in the past. However, this often fuels consumers' determination to fight for their rights and move toward empowerment.

Symptom management and non-linear journey. The process of recovery occurs in small steps (Ralph, 2007) and does not necessarily mean a complete remission of symptoms (Davidson et al., 2007). The way in which consumers choose to manage their symptoms varies for individuals, and individuals are active participants as opposed to recipients of services. Happell (2008) utilized a qualitative exploratory method with sixteen consumers. Happell found that consumers identified treatment as a factor that facilitates recovery. Some of the specific treatment themes included medication, spiritual therapy, counseling, crisis management planning, and cigarettes. Essentially, recovery involves improving one's quality of life, a sense of well-being, and the determination to reach new potentials over time (Young et al., 2003).

Connections. The process of recovery does not occur in isolation (Davidson et al., 2007, Ralph, 2007). Recovery involves meaningful activities, support, partnerships, and expanding one's social roles. This process does not occur in a vacuum but with encouragement, particularly encouragement to participate in the world (Ralph, 2007). The activities and roles that individuals choose to participate in are less important than the personal meaningfulness and their perceived value to the community (Davidson et al., 2007). Social connectedness including staff and peer relationships has been identified by some consumers as more important than medication and other strategies (Happell, 2008).

Recovery experience in forensic patients. Laithwaite & Gumley (2007) conducted a study that explored the recovery process of 13 maximum security forensic patients detained in the State Hospital in Northern Ireland and Scotland. Participants included individuals with a mental illness and with violent or criminal propensities who had experienced symptoms of psychosis. Interviews with all participants were audio

taped and transcribed. Materials were coded line-by-line for micro-codes and analysis identified emerging codes to compare and contrast.

Most participants found admission to the hospital frightened them and exacerbated their symptoms (although some found a sense of safety and had a positive experience). Participants identified relationships with staff as helpful in adapting to the new hospital environment. Participants reported feeling entrapped or "stuck" because they didn't know how long they would be detained, which they would have known had they been sentenced to prison. This created feelings of uncertainty, uneasiness, establishing a negative effect on their mood. The participants reported that they had difficulty coping with this ambiguity and utilized distractions such as cooking, sports, recreation, talking with others, and focusing on the present moment to help cope.

Participants also spoke about the importance of relationships with staff and others which helped to facilitate change as well as to understand past experiences by providing them with the language that helped them make sense of their experiences. However, due to participants' negative past relationships, the need for trust and mutual respect with staff was imperative. The participants also identified building bridges with family as helping to develop trust and respect. Additionally, a reciprocal theme emerged from the findings that included relationships and a changing of the sense of self. Participants reported that being in the hospital made them think about past experiences and led them to attempt to build new relationships. Again, this helped them learn about themselves, about the reciprocity of relationships, and about how they could have done things differently.

Valued outcomes were also a theme that emerged from the findings, and these were important to the recovery process. This included developing a good life that involved achievements and confidence building. Participants spoke about increased awareness of triggers to prevent relapse and said they learned these skills by discussing experiences with other patients as well as through psychotherapy.

Recovery-Oriented Systems: Characteristics and Implementation

During the past decade, with the Surgeon General's Report on Mental Health and the publication of the President's New Freedom Commission on Mental Health's Final Report, *Achieving the Promise: Transforming Mental Health Care in America* (DHHS, 2003), recovery principles have been the focus of transforming mental health practice and policy (Anthony, 2000; Davidson et al., 2005; Davidson et al., 2006; Ralph & Corrigan, 2007). During this time, there has been an emergent emphasis on exploring mental health service delivery to ensure services reflect recovery principles (Salyers et al., 2007). The mental health care transformation suggested by the New Freedom Commission recommends the following:

> To achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current treatments and best support services. Advances in research, technology, and our understanding of how to treat mental illnesses provide powerful means to transform the system. In a transformed system, consumers and family members will have access to timely and accurate information that promotes learning, self-monitoring, and accountability. Health care providers will rely on up-to-date knowledge to provide optimum care for the best outcomes. When a serious mental illness or a serious emotional disturbance is first diagnosed, the health care provider — in full partnership

> with consumers and families — will develop an individualized plan of care for managing the illness. This partnership of personalized care means basically choosing *who*, *what*, and *how* appropriate health care will be provided:
>
> - Choosing which mental health care professionals are on the team,
> - Sharing in decision making, and
> - Having the option to agree or disagree with the treatment plan.
>
> The highest quality of care and information will be available to consumers and families, regardless of their race, gender, ethnicity, language, age, or place of residence. Because recovery will be the common, recognized outcome of mental health services, the stigma surrounding mental illnesses will be reduced, reinforcing the hope of recovery for every individual with a mental illness. (DHHS, 2003, p. 6)

Characteristics of recovery-oriented systems. Anthony (2000) suggested that recovery-oriented services should include treatment to reduce symptoms, crisis intervention, case management, rehabilitation, enrichment which includes fulfilling activities, rights protection advocacy, basic support such as food and housing, self-help, and also wellness and prevention. Recovery oriented services should involve consumer and family involvement (Jacobson & Curtis, 2000). Consumer involvement should occur at all levels of the organization and are sought for employment and peer support (Anthony, 2000). Services also emphasize employment and education (Sowers, 2005), relapse prevention and management, defining and measuring outcomes, revision of key policies, as well as stigma reduction (Jacobson & Curtis, 2000). For instance, the Community Support Program Advisory Committee for the Ohio Department of Mental Health developed a recovery-oriented system compatible with the one described above,

entitled, The Recovery Concept: Implementation in the Mental Health System. The CSP Advisory Committee suggested several themes to enhance the recovery process and includes services that address a variety of consumer needs including jobs, power and control, stigma reduction, peer support, family support, community involvement, access to resources, education, and clinical roles and relationships.

Recovery-oriented services encourage the locus of control to become internal, with interventions focused on enabling the individual to take responsibility for decisions and for the consequences of those decisions (Frese et al., 2001). For instance, one treatment goal may include improvement of autonomous decision making abilities. Furthermore, self-determination should be encouraged and respected by helping professionals as well as by those in the overall culture. Collaboration between staff and consumers are highlighted (Jacobson & Greenley, 2001). Borg and Kristiansen (2004) conducted qualitative research utilizing 15 mental health service recipients to explore common factors among consumer perspectives regarding helping relationships. The researchers found several common factors including shared power, conveyance of hope, availability, openness to diversity of treatments, stretched boundaries from the "professional role," collaboration, and acknowledgment of the individuality of the change process.

As an introduction to state legislatures, the National Alliance for the Mentally Ill has published and disseminated the Omnibus Mental Illness Recovery Act: a Blueprint for Recovery originated from evidenced-based programs that have demonstrated critical components of recovery (NAMI, n.d.). NAMI suggests eight components that can be immediately implemented. The eight components include consumer and family planning

of mental health services, equal health care coverage, access to new medications, assertive community treatment, work incentives, decreases in life-threatening harmful actions including restraint, reduction in criminalization of mentally ill individuals, and access to safe and affordable housing located by community-based services.

Recovery Oriented Systems can also be delineated from what they are not (Salyers et al., 2007). For instance, programs utilizing the coercive paternalistic approach with a primary focus on medication adherence and stabilization but do not encourage self-determination are not recovery-oriented systems. However, a recovery-oriented approach will not discontinue offering treatment to reduce symptoms of mental illness and rehabilitative interventions to address impairment (Davidson et al., 2006). Instead, recovery-oriented systems will continue to provide access to services, tools, and environmental accommodations that promote the inclusion of the individual in the community to carry on their regular lives with mental illness as one component of life (not unlike living with other health conditions).

Coercive treatments such as seclusion and restraint are considered incompatible with recovery-oriented systems (Sowers, 2005; Ashcraft & Anthony, 2008). Ashcraft and Anthony describe an initiative by META Services that was designed to eliminate seclusion and restraint from two crisis centers serving about 14,500 patients/consumers each year. Individuals with a range of situations and mental health issues were served, and 32 % of all admissions were involuntary. The involuntarily admitted individuals were brought by police and other individuals who felt the individuals were a danger to themselves and others. The initiatives elimination strategies included strong leadership direction, policy and procedural transformation, staff training, and consumer debriefing

as well as standard progress feedback. A manual was developed outlining the details of these strategies. The services were then evaluated for 58 months by obtaining relevant data from existing records collected by the quality assurance department. The larger crisis center obtained zero seclusions for one month in ten months, and zero restraints for one month in 31 months. The smaller crisis center obtained the same results in two months and 15 months. Staff injury and medication use were not increased. This initiative suggests that elimination of seclusion and restraint is a legitimate goal.

Crisis planning and advanced directives are proactive recovery-oriented services that can reduce coercive interventions including involuntary commitment, restraints, seclusion, and forced medication (Jacobson & Curtis, 2000). This includes identifying crisis triggers and emphasizes self-management skills. The crisis plan can include preferences for a preferred treatment facility and medication.

Implementing recovery-oriented services. Although the recovery movement and recovery-oriented services have taken center stage in the mental health field, there are still limited training opportunities for mental health professionals to transfer recovery principles into practice (SAMHSA, n.d.). In response to this need, SAMHSA has initiated the Recovery to Practice project which includes two components. The first component is the creation of a Recovery Resource Center for providers to utilize and obtain training, materials, and technical assistance during the mental health transformation process. The second component includes creating and distributing recovery-oriented materials. SAMHSA has approved funding to five national mental health associations to develop educational materials and train thousands of professionals regarding recovery-oriented services. The five national mental health professional

organizations include the American Psychiatric Association, American Psychological Association, American Psychiatric Nurses Association, Council on Social Work Education, and the National Association of Peer Specialists. The recovery-based materials and training will be based on SAMHSA's (2005) national consensus statement on mental health recovery that has indicated 10 fundamental components of recovery. The 10 components include:

- Self-direction in which consumers determine their own route to recovery.
- Individualized and person-centered services that acknowledge multiple pathways to recovery, strengths, individual needs, preferences, experiences and cultural background.
- Empowerment including the consumer's right to participate in all decisions from an array of service options and express individual needs, desires, and aspirations.
- Holistic approaches to recovery which encompasses the whole individual, addressing housing, employment, education, mental health, medical health, naturalistic services, spirituality, creativity, social systems, community, and family support.
- Non-linear approach to recovery viewed as a continual growth process as opposed to a step by step change process.
- Strength-based services emphasizing numerous capacities, resiliencies, talents, coping mechanisms, and intrinsic worth of the individual.
- Peer support provided by other consumers.

- Respect for the consumer by the community, systems and society to protect consumer rights and eradicate discrimination and stigma.
- Responsibility for the consumers' own self-care and recovery.
- Hope that promotes the vision of a better future.

Recovery and Mental Health in the Criminal Justice System and the Forensic System

In current literature, it is reported that the largest proportions of people with mental illness in the United States are found to be in correctional environments (Way et al., 2008; Cloyes, 2007). It is estimated that between 600,000 and one million people that are diagnosed with mental illness are booked in jails and prisons (Cloyes, 2007; Hatcher, 2007). This comprises about 56% of the inmate population (Cloyes, 2007). Thus the prevalence of people with mental illness appears to be greater in prisons than in the community and in hospital settings (Diamond et al., 2001; Cloyes, 2007).

These high prevalence rates have been thought of as the unintended consequences of several major historical events including deinstitutionalization, more rigid criteria for civil commitment, inadequate community support for individuals with mental illness, problems accessing community support for offenders with a mental illness, violence at the time of arrest, and the attitudes of police officials as well as of society (Lamb et al., 1999). Moreover, reform efforts were the primary force that fueled deinstitutionalization, with care for individuals shifting to the community (Dumont & Dumont, 2009). However, in 1968 Richard Nixon terminated the funding for mental health reforms, and United States reform efforts failed to meet their anticipated objectives.

Offenders with mental illness are admitted predominantly to treatment for mental illness through the judicial system (Kravitz & Kelly, 1999). For instance, adjudicated offenders found Not Guilty by Reason of Insanity can be involuntarily committed for mental health treatment despite their status as "nonsentenced offenders." Commitment minimally involves an initial in-patient evaluation and requires court approval for any off-grounds privileges and for discharge from institutional care into the community. The court closely supervises these individuals via a process called conditional release and can unilaterally revoke community placements and recommit individuals upon evidence of symptomatic relapse or treatment non-adherence (Kravitz & Kelly, 1999). Thus the management of deviant behavior resides in the realm both of the mental health system and of the criminal justice system (Fisher et al., 2002). Furthermore, although principles of recovery have become the focus of mental health care in the United States, they have just begun to enter the forensic system (Hillbrand & Young, 2008).

Offenders in Forensic Settings

The term *forensic* typically can be defined as a legal status of an individual with a mental illness who is involved in the criminal justice system (Linhorst & Turner, 1999). In recent decades, the mental health system and the criminal justice system have developed new services specifically for individuals with this status (Fisher et al., 2002). These services include jail diversion programs, outpatient forensic evaluation in court clinics, and inpatient forensic systems in many states. The National Association of State Mental Health Program Directors Research Institute (2009) maintains a data base called state mental health agency profiles system, which compiles information regarding the states that currently utilize state psychiatric hospital beds for forensic individuals. The

database indicated that 44 states currently utilize state hospital beds for acute inpatient forensic care (less than 30 days), 46 states with intermediate inpatient forensic care (39 days), and 47 states with long term forensic inpatient care (more than 90).

Forensic systems have several functions for criminal defendants with a mental illness including assessment of competence to stand trial and criminal responsibility. The types of individuals involved in the forensic system include court-ordered pretrial defendants for psychiatric evaluations, defendants found to be incompetent to stand trial, defendants found not guilty by reason of insanity (NGRI), defendants guilty but mentally ill, as well as defendants that committed sex crimes (Linhorst & Turner, 1999). As cited in Linhorst and Scott (2004), the National Association of State Mental Health (2002) conducted a survey indicating that 7,386 forensic patients occupied state hospital beds in thirty-one states. Additionally, thirty-two percent of state hospital beds in twenty-nine states were occupied by forensic populations with the two largest forensic populations being NGRI (37 %) and incompetent to stand trial (33 %). Some of the remaining forensic populations that occupied state hospital beds in the twenty-nine states surveyed were inmates transferred from state prisons, sexual offenders, individuals for pretrial evaluation, and individuals found guilty but mentally ill. Furthermore, at times individuals are arrested, and their behavior is considered bothersome to the public but does not necessitate involuntary hospitalization. They are often charged with petty crimes and arraigned in court (Fisher et al., 2002). The judges then order them to be hospitalized for competency to stand trial, but are really attempting to facilitate their hospitalization under criminal rather than civil authority.

Populations Served in the In-Patient Forensic System

Competency restoration. A defendant must be competent to confess, plead, stand trial, waive legal representation, refuse the insanity defense, be sentenced, and have the sentence executed (Huss, 2009). Competency refers the defendant's present mental state at any time of the adjudication process as opposed to insanity which refers to an individual's mental state at the time of the crime. Mental illness is not required for incompetency, and defendants must know the meaning and consequences of their actions and charges.

Competency restoration involves different treatment goals from individuals on other psychiatric units (Sharfstein, 2009). Competency restoration refers to the process by which a defendant deemed incompetent is restored to competency so that legal proceeding can continue (Huss, 2009). Competency restoration can be achieved via psychotropic medication or psychotherapy, as well as by legal psychoeducation. As the defendant's competency capacities are restored, the defendant is promptly returned to the court (Sharfstein, 2009). Thus defendants deemed incompetent have a relatively short hospitalization (Huss, 2009).

The insanity defense. Not Guilty by Reason of Insanity (NGRI) is the most controversial defense in the criminal justice system (Perlin, 2000). The public is fascinated with high profile cases in which a person admits to the act but claims insanity at the time of the crime (Huss, 2009). One of the most popular NGRI acquittals of the twentieth century is that of John W. Hinckley's shooting of President Reagan, which resulted in a public outcry to narrow and restrict the use of the NGRI defense (Perlin, 2000, Blunt & Stock, 1985).

Traditional legal examination states that there are three elements for a crime to be considered a crime which include guilty mind (*mens rea*), a proscribed act (*actus reus*), and the prescribed punishment (Blau et al., 1993). NGRI defense is based on a lack of *mens rea* or guilty and wrongful purpose (Huss, 2009; Blau et al., 1993). Essentially NGRI is a legal defense that removes legal responsibility, and the person is acquitted (Huss, 2009). It is considered a legal compromise to a moral dilemma due to society's view that individuals who are not aware of or in control of what they are doing should not be punished. Additionally, this defense focuses on the individual's mental state at the time of the crime. Thus, from a psychological perspective, the NGRI defense relies on the individual's psychological functioning; from a societal perspective it lies in treating the individual differently due to their mental condition (Slovenko, 1999).

Mental disease or defect is required for the insanity defense (Slovenko, 1999). However, insanity is a legal term as opposed to a psychological term (Huss, 2009). Although mental illness or defect is central to the insanity defense, an individual with mental illness is not necessarily insane. Insanity's level of impairment is more specific, and not all mental illness is sufficient for an insanity defense.

Perlin (2000) suggests that there are several myths regarding the insanity defense that have been revealed, empirically, to be unequivocally disproven. The insanity myths are as follows:

Myth 1: The insanity defense is overused.

Myth 2: Use of the insanity defense is limited to murder cases.

Myth 3: There is no risk to the defendant who pleads insanity.

Myth 4: NGRI acquittees are quickly released from custody.

> Myth 5: NGRI acquittees spend much less time in custody than do defendants convicted of the same offenses.
>
> Myth 6: Criminal defendants who plead insanity are usually faking.
>
> Myth 7: Most insanity defense trials feature "battles of the experts."
>
> Myth 8: Criminal defense attorneys-perhaps inappropriately-use the insanity defense plea solely to "beat the rap." (Perlin, 2000, p. 228-229)

Research indicates that the insanity defense is seldom used in criminal trials, with even fewer defendants being acquitted (Blau et al., 1993; Perlin, 2000; Huss, 2009). The frequency of use and success rates of the NGRI defense are grossly overestimated with only about one percent of all felony cases utilizing the insanity defense, and this is successful only about a quarter of the time (Huss, 2009; Perlin, 2000). Moreover, NGRI defendants are found to serve longer periods of confinement than similarly charged defendants (Melville, 2002; Perlin, 2000; Huss, 2009). Perlin (2000) suggest that 95 % of NGRI acquittees are hospitalized and most states have provisions for immediate confinement (Huss, 2009). However public misconceptions fuel legislative reform measures which frequently are not based on empiricism; these have led to extremely restrictive and a morally out-of-date defenses (Perlin, 2000). Four states have gone as far as abolishing the NGRI defense, and these states include Idaho in 1982, Utah in 1983, Nevada in 1995, and Kansas in 1996.

Individuals found NGRI are often brought to an in-patient forensic unit upon acquittal (Sharfstein, 2009). At the forensic unit, care often exceeds what is required to treat the acute aspects of their mental illness (Carroll et al., 2004) and is challenging both for the client and for the treatment team (Sharfstein, 2009) . Furthermore, adequate

discharge planning is an important component of care in a forensic unit because many individuals are returned to the community when their capacities are deemed to be restored.

Guilty but mentally ill. The standards for the insanity defense have been revised over time due to the concern that the defense is too lenient or at times too severe (Huss, 2009). In the 1970s, a completely different alternative was created to the insanity defense. Guilty but Mentally Ill (GBMI) was created as a compromise between guilty and NGRI (Perlin, 2000; Blunt & Stock, 1985) and occurred partially in response to an offended public conscience regarding the idea that NGRI defendants "get off easy" (Melville & Naimark, 2002). GBMI verdicts were introduced to reduce successful NGRI verdicts (Melville, Naimark, 2002; Huss, 2009). Michigan was the first state to implement a GBMI verdict (Blunt & Stock, 1985; Huss, 2009) with 13 states to follow (Melville & Naimark, 2002). GBMI defendants have the option of waiving their rights to a trial as opposed to a NGRI plea (Blunt & Stock, 1985).

In the GBMI defense, the individual is considered to have a disturbed mind but does not meet the threshold to be completely exculpated (Blunt & Stock, 1985). Statutes for the GBMI defense include being guilty of an offense, being mentally ill at the time of the defense, but meeting criteria to be considered legally insane at the time of the offense (Blunt & Stock, 1985; Huss, 2009). However, the court may still impose any sanction to a GBMI defendant as it normally would to a defendant found guilty (Blunt & Stock, 1985).

Most GBMI verdicts require treatment as a condition of parole (Melville & Naimark, 2002). Defendants found GBMI begin their sentence by receiving mental

health treatment (Huss, 2009; Blunt & Stock, 1985). Once treatment is determined to be complete, they are required to serve the remainder of their sentence in a correctional facility. However, the Department of Corrections or the Department of Mental Health may provide treatment to these defendants (Blunt & Stock, 1985). Thus, some individuals may not obtain special mental health treatment in a hospital (Huss, 2009). Mental health organizations have opposed the GBMI verdict because of this possibility (Huss, 2009) because of the latitude the verdict allows to avoid difficult moral and social issues regarding insanity (Huss, 2009; Melville & Naimark, 2002).

Forensic In-patient Treatment

Forensic in-patient facilities treat individuals with mental illness referred by the criminal courts (Sharfstein, 2009; Kaltiala-Heino & Kahila, 2006). Treatment in an in-patient forensic unit consists of assessment of competency or more extended treatment in a secure facility. The forensic mental health system is expected to service two potentially conflicting tasks including public protection and ethical patient care (Carroll et al., 2004). Therapeutically, forensic units often function similarly to general psychiatric units but the clients are often enmeshed in the criminal or civil legal system (Sharfstein, 2009; Kaltiala-Heino & Kahila, 2006). Professionals at these facilities are often in the middle of many adversarial agents due both to the mental health and to the legal components of the clients.

Implementation of recovery principles has been extremely slow and almost non-existent in the forensic system (Singh & Tosh, 2005). External agencies such as the Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, Medicare, Medicaid, and the federal

Department of Justice can be extremely prescriptive in mandated settings, and treatment planning is often riddled with legal regulations and standards from state and federal authorities. State and federal agencies are regulatory in many aspects of mandated treatment evidenced in the content of treatment plans, roles of treatment team members, the nature of assessment, case formulation, diagnoses and differential diagnoses, as well goals and objectives of treatment, interventions, discharge planning, and documentation and measurement of outcomes. Thus, state hospitals often find themselves in a dilemma to fulfill regulatory expectations that often fall on a continuum from adherence to a rigid medical model to a liberal recovery model of care.

Perlin (1991) suggests the nature of forensic relationships inherently is power imbalanced. Forensic mental health professionals are not intervening for therapeutic purpose but in response to several external entities such as the litigation, attorney, court, prosecuting agency, and the state mental health facility itself. Thus the presence of a third party necessitates an understanding that any forensic relationship as containing a power imbalance due to the dangers of dual loyalties or dual agency. This involves a consideration of the mental health professional's role and whether or not he or she can be an agent both of the client and of the third-party institution. Perlin (1991) suggests several conflictual situations that may arise, one of which includes NGRI acquittees' petitioning for release.

Beyond the multiple interests of mental health professionals and the employer, there are also community and social interests that may consciously or unconsciously play a role in power imbalances within the forensic arena (Perlin, 1991). For instance, considerations of conditional release for a notorious NGRI acquittee or availability of

public hospital space are some instances in which social interests are weighed. Furthermore, harm may come to forensic clients directly from the employment of therapeutic skills designed to help individuals. This is particularly true of skills utilized to elicit information that may not otherwise be disclosed and may possibly be used to hurt them.

Clinical principles alone are insufficient when working with offenders with mental illness (Carroll et al., 2004). Management within forensic services differs not only because of dual loyalties but also because of the perceived severity and violent outcome of the offenses as opposed to clinical severity of illness. Thus, in the forensic service system there is a need to balance public protection and ethical patient care. Furthermore, public safety leads the political agenda with the media, politicians, and public participating in debates that are often ignorant of empirical data and relevant experience. Carroll et al. (2004) suggests that the competing political and ethical demands can best be conceptualized by accuracy of assessing future risk and the severity of the index offense.

The unique issues that exist in the forensic mental health system challenge a patient-centered approach and notions of professional ethics including beneficence, non malfeasance, autonomy and justice. Carroll et al., (2004) suggests that long term hospitalization is unlikely to work well and may do harm particularly if the environment is not stimulating. Additionally, involuntary detention challenges the aspiration of client autonomy unless it is limited to the time required to ameliorate the most severe symptoms of the individual's mental illness.

Forensic patients are supposedly mandated to detainment and supervision due to the potential future risk, based on previous behavior (Carroll et al., 2004). However, the resolution of overt symptoms does not usually indicate the removal of those controls. Thus, the removal of criminal sentencing may not prove advantageous for forensic clients. If the forensic client's symptoms persist and continue to provoke fear in the people in charge of release decisions, then hospital detainment may be indefinite. For those forensic clients that are released from detainment, intrusive supervision in the community as well as compliance with a variety of conditions is typically implemented.

Although the level of severity of mental illness varies among forensic patients, there is not evidence that individuals who commit a serious offense are more disabled than individuals who commit a less serious crime (Carroll et al., 2004). However in practice, the length of time in detention will more likely reflect the seriousness of the crime committed as opposed to the seriousness of mental illness or true safety considerations. Moreover, tribunals, courts, and political departments rather than clinicians generally make discharge decisions. Clinical evidence is presented, however, with the primary focus of this evidence being future risk.

Furthermore, clients at in-patient forensic facilities are doubly stigmatized due to mental illness and criminality, making discharge planning both complicated and controversial (Sharfstein, 2009). However, discharge planning continues to be an important component in forensic facilities because many clients are returned to the community when capacities and/or competencies are deemed restored. Human rights of individuals on the forensic unit are also a primary focus for legal advocates due to the mandated nature of treatment.

The forensic unit. Although regulations and functioning of inpatient state hospitals vary from state to state, for informational purposes it is beneficial to explore the specific functioning of one state inpatient forensic facility. For this reason, the Missouri forensic system will be reviewed. Missouri statute identifies three types of forensic patients including offenders who are court ordered for pretrial psychiatric evaluation (primarily via outpatient but occasionally hospitalized) as well as individuals found not competent to stand trial, and NGRI (50 % of forensic patients) (Linhorst & Turner, 1999). Similar to legislatures in many states, the Missouri legislatures identifies the highest priority as public safety, particularly for NGRI individuals. The factors that reflect the public safety priority consist of automatic hospitalization for most NGRI individuals at acquittal; more stringent release criteria for NGRI individuals compared with civilly committed individuals; release materials viewed by multiple parties that include the attorney general's office and prosecuting attorney; final release authority by the circuit court judges; conditional release involving intensive community monitoring programming, and the potential for indefinite in-patient hospitalization or community monitoring.

There are four forensic hospitals in Missouri. Two of the hospitals, in most instances, segregate forensic patients from non-forensic patients and the other two hospitals group patients based on treatment needs. The security level within these hospitals consists of three levels including maximum security, minimum security with locked wards, or minimum security with open wards. The security at these hospitals is maintained by physical structures. Individuals at minimum security hospitals have the chance to earn grounds privileges but could require a staff escort. Approximately one-

fifth of individuals were restricted to locked units with no grounds privileges and a secured outside area. Approximately one-fourth of individuals had staff-escorted grounds privileges and the remaining 50 % had unescorted privileges.

The majority of NGRI individuals were housed in minimum security hospitals within locked wards. NGRI individuals in comparison with voluntary individuals had a higher percent of no grounds privileges (21.6 % compared with 15.4 %). However, the NGRI individuals that were permitted to obtain grounds privileges had a higher percentage of those privileges being unescorted (59.8 % to 49.0 %).

Missouri has some of the most stringent criteria regarding release for NGRI individuals. Clear convincing evidence must be demonstrated that the individual seeking release will not commit a dangerous act again. This is in contrast to the criteria regarding release for those civilly committed individuals in which the criteria includes demonstrating that the individual will not commit a dangerous act to self or others. The requirement to demonstrate clear and convincing evidence that someone is not dangerous is challenging and is more likely to result in continued hospitalization.

Literature of Recovery-Oriented Principles and Services in Forensic Settings

Despite the current focus of recovery-oriented mental health transformation in the United States, there is a dearth of literature regarding the implementation of recovery-oriented principles and services in forensic settings. Further research is needed to illuminate the importance of recovery-oriented services in the forensic arena as well as the unique strategies that facilitate implementation and the unique barriers that may impede transformation. The current literature indicates that recovery principles are an

important component of forensic treatment and these will be discussed in the following sections.

Hillbrand and Young (2008) suggest the cognitive processes that stimulate violence and bring forensic clients into treatment are often a result of loss of hope. Thus, instilling hope while managing anger associated with despair and desperation often experienced by inmates is an essential treatment goal in forensic settings. Hope, or the belief that a goal can be achieved, is prominent among the factors that aid in forensic client's recovery.

Hillbrand and Young (2008) suggest that the loss of hope plays a role in externally directed aggression. When loss of hope regarding a peaceful solution to a painful problem occurs, removing the threat through retaliation is perceived as the only option. Often this process results in a desperate violent act in which the individual feels justified because of his or her distorted beliefs. Mental health treatment then attempts to help clients increase their awareness of their distorted thinking and the wrongfulness of the violent act. Clients may further become hopeless due to feelings of guilt that they should not be forgiven by themselves or others.

Hillbrand and Young (2008) suggest several ways to facilitate hope in a forensic setting. Forensic professionals listening to the clients' despair empathically but without identifying with it and with feeling despair themselves can restore hope. Weekly psychotherapy sessions that routinely take place create the expectation and hope that future sessions will occur. This also creates a place where the client can explore desperation and painful experiences allowing for relief of these feelings for the rest of the week.

Hope in relationship to forensic risk assessment needs to be better understood (Hillbrand and Young, 2008). Individuals that are feeling hopeless, with nothing to lose are prone to desperation. They can be exceptionally dangerous; individuals such as these are found on death row. Hillbrand and Young suggest that professionals conducting risk assessment may not be aware of the significance of hope as a protective factor. Additionally, a forensic client's suicide risk typically grows out of hopelessness and despair. Forensic treatment planning can instill hope in forensic clients via positive behavioral support planning. For instance, forensic professionals can focus treatment planning on adaptive behaviors such as new coping skills as opposed to focusing on problem behaviors. Some of the coping skills in this model may include leisure activities, self-soothing techniques, illness management, self-efficacy improvement, and reciprocity of interpersonal relationships. Furthermore, staff can instill hope only if they themselves are hopeful. Ultimately, the emphasis on hope drives individuals on a trajectory toward greater autonomy and freedom.

Human rights are another core principle of recovery and can act as an important ethical and therapeutic resource for forensic psychologists (Ward, 2008). Human rights help direct therapeutic attention to provide appropriate skills-oriented programming. For instance, programming should ensure that forensic clients gain the ability to identify personal values and projects, the ability to implement them in the environment where they will most likely be released, and the ability to understand the importance of respecting others rights.

Furthermore, forensic clients do not forfeit their human rights because they have committed offenses that have violated the human rights of others (Ward, 2008). Ward

suggests that individuals who have committed crimes retain their human rights although they may have some of those rights legitimately restricted. Thus it is essential to differentiate between forfeiture and curtailments of human rights, the former enlisting a loss of rights in their entirety. Moreover, human rights warrant individuals to entitlements but also confer duties to respect the rights of others. If individuals impede the rights of others, restriction in the form of social sanction or punishment is justified. Again, this does not justify forfeiture of all human rights but calls for a restriction of rights such as freedom of movement and other restrictions.

Shiva et al. (2008) explored the impact of provider and client characteristics in psychiatric civil and forensic inpatient satisfaction with care. The study was conducted in the Forensic and Inpatient Psychiatry Divisions in New York City between 2002 and 2007. Shiva matched 384 inpatients (188 civil; 196 forensic) on several demographic characteristics including age, race, length of stay and Axis 1 and Axis 2 diagnoses; these were evaluated for significant differences. Participants completed the Inpatient Satisfaction Questionnaire, a measure validated in both civil and forensic settings. A series of univariate analyses of variance were utilized to test main and interaction effects for mean satisfaction ratings. Significant differences in satisfaction rating were found for race and for perceiving a problem with staff. White and Hispanic patients were more satisfied with care than were Black patients, and patients that perceived a problem with staff were less satisfied with care than were those who did not. There were no significant findings found for unit type, age, diagnosis, or perception of connection to staff. These findings can inform providers to target patients who are less satisfied with patient care and ultimately increase overall satisfaction of care.

Carroll et al., (2004) suggests that trusting therapeutic relationships are essential to accurate risk assessment. Risk assessment primarily relies on the cooperation and honesty of the patient. Thus, the patient's role is crucial.

Implementation of recovery oriented services in inpatient forensic settings. Again, there is a lack of literature regarding the implementation of recovery services in the forensic arena. However, the National Consensus Meeting on Person/Family-Centered Planning (Singh & Tosh, 2005) indicated several critical barriers to implementing wellness and recovery planning that is specific to individuals with mental illness who have committed crimes and who have been involuntarily detained. The barriers specific for forensic in-patient settings as well as strategies to overcome such barriers will be discussed.

Administrative support. At times, administrators do not fully realize the importance of transforming the forensic facility into a therapeutic climate conducive to recovery. Administrative staff should perceive themselves as support staff and provide the necessary resources for recovery. This change needs to occur on all levels including the facilities mission, vision and values as well as policies and procedures that support recovery. Administrators can overcome such barriers through systemic alterations and a quality management system that implements the facility's mission, vision, values, policies, and procedures to reflect recovery principles.

Forensic hospital and mental health. The focus of an individual's detainment in a forensic hospital is the legal reason for admission, opposed to the individual's mental health issues. Thus intervention focuses on meeting the legal requirements for discharge, oftentimes leaving other mental heath issues unaddressed. A holistic approach to a

recovery plan is reflective of a recovery-oriented system. Administrators at forensic hospitals can train staff regarding recovery-oriented service principles which encourage a holistic approach.

Staffing mind shift. At times, staff that have been employed for extended periods of time at facilities have become institutionalized in their thinking regarding staff roles and service delivery. These individuals can be considered to be in the precontemplation or contemplation stage of change and will encounter difficulty embracing a radical model shift from old to new. Again, staff training regarding recovery principles is beneficial as well as implementation of positive behavior supports in a therapeutic milieu. Moreover, cognitive behavioral techniques may be utilized with staff to reframe staff cognitions that impede care.

Professional roles. In previous models, the therapists typically determined their roles regarding client interactions as well as the services provided to the clients. Therapists were not held accountable for timely client improvement outcomes. In the recovery model, there is not one therapist that is preeminent, but tasks are delineated to the professionals who can best execute the service. Restructuring of professional duties should be considered. Additional training in recovery principles and experience in implementing recovery-oriented services may facilitate this shift.

Moreover, many facilities do not have the means to provide all the services that exist in a recovery oriented model. Thus, providers develop programming based on models that provide a centralized system for scheduling services, such as a treatment mall. Providers are expected to collaborate to provide services that include treatment, rehabilitation, group enrichment, and individual psychotherapy. Providers at first may

resist this shift due to the perception that they are therapists and not teachers. Providers' beliefs need to be reframed to incorporate the idea that their role is to serve the individual.

Family members and advocates. Although traditionally, family members were asked to participate in care and service of their family member, in a recovery-oriented service model family members are encouraged to participate in a much more active role. However, cultural, language, and time constraints are often barriers to family participation. Thus, it is important to schedule convenient time for family members to participate in care and services or to provide an 800 number for family members with transportation issues. Cultural brokers can be incorporated into family participation to overcome cultural and language barriers. Psychoeducation and training regarding mental illness, problem solving, family support, and case management should be offered as well.

Legal mandates and choices. In the recovery model, individuals are not required to obtain insight into their mental illnesses. Individuals are encouraged to gain the ability to respond to behavioral antecedents and endpoints in a way that does not negatively impact functioning. At times, however, at times legal mandates require an individual to be transitioned or to have insight into their mental illness that is in conflict with the values of recovery. Finding a middle ground that meets the legal requirements within a recovery-oriented service system is imperative.

Choice and empowerment. Choice allows individuals to make decisions that may be considered contrary to their well-being. Professionals can educate clients regarding the consequences of their decisions so they can make more informed choices. Additionally, traditional service implementation considered the role of the clients

regarding care and services as a passive one. In recovery-oriented systems, the individual is encouraged to take an active role in every part of care and treatment planning. Individuals are also encouraged to take part in ward governance including representation that develops policies and procedures. Individuals need to be educated about their new roles and encouraged to participate in them.

Hope. Hope is a central principle of recovery. Oftentimes, forensic clients do not see a better future because of their legal involvement and persistent mental illness. The instillation of choice includes providing these individuals with real choices within the mandated setting. Providers need to instill hope in the belief that individuals' actions can make a difference and change their future pathway. Providers will not be able to instill hope in clients if they, themselves, do not believe that clients can change. They must carry hopefulness for the individuals that are feeling hopeless until these individuals are recovered enough to feel hopeful once again.

Hospital environment. Many state hospitals that provide therapeutic services for forensic clients are overcrowded, dismal, and bleak in very old buildings that are either too small or too large. Therapeutic space appropriate for individual and group therapy away from the unit is very difficult to obtain. In addition, the traditional milieu of service delivery is difficult to dismantle. Coercive techniques such as seclusion and restraint have also often been utilized. All of these factors are adversarial to recovery. Unfortunately, to renovate the physical environment of these state hospitals to become aligned with recovery principles is both extremely costly and time consuming for the state and hospital administration. Moreover, many of the hospital restrictions that are expected of clients will need to be reduced, such as wearing the same color clothing so

clients are easily identifiable. Staff training that involves recovery principles, mindfulness, behavior management strategies, conflict resolution, and cognitive behavioral techniques will aid in service transformation and encourage compassionate non-judgmental services.

Exploring Facilitating Strategies and Barriers to Recovery-Oriented Care in In-patient Forensic Hospitals

The current study is designed to examine and operationalize how recovery oriented services have been implemented by program directors and staff members in forensic settings. The study seeks to describe the facilitating conditions that enabled recovery strategy implementation, the specific strategies used to implement principles of recovery oriented care, and problems, challenges, and/or barriers in applying recovery oriented services in forensic settings. A survey and a semi-structured qualitative interview will be constructed, based on the literature that has been presented here to illuminate the unique challenges that exist in the forensic arena.

Chapter 3: Interview Questions and Hypotheses

This study combined both qualitative and survey methods to explore and gather information regarding Recovery-Oriented Service implementation in inpatient forensic settings. There are several barriers that have been identified in applying recovery oriented care in inpatient forensic settings; this study has sought to elucidate these challenges, and to identify facilitating strategies that overcome these obstacles. This study also sought to explore how administrator and provider attitudes and knowledge facilitate or challenge this process.

Interview Questions

A structured interview with forensic hospital administrators consisted of the following:

Research Question: What is the experience of service providers regarding the recovery transformation process within the in-patient forensic hospital system?

1. How are you implementing Recovery-Oriented Services at your facility?
2. What are the obstacle/barriers?
3. What are the strategies you have used to overcome those barriers?
4. What are the strategies that facilitate Recovery-Oriented Services?

Hypotheses

The surveys that were utilized in this study can be found in Appendix A. The hypotheses are as follows:

H_1: Direct service providers who report significantly higher rates of training and knowledge in recovery oriented care, as compared with direct service providers with

lower levels of training and knowledge, will also report more positive attitudes and increased levels of skills in recovery oriented care.

Rationale: Staff training is one component critical to successful implementation of recovery-oriented care (Becker et al., 1998). Organizational change necessitates staff training to develop new knowledge and enhanced competencies (Pascaris et al., 2008). Gudjonsson et al. (2010) found that, after implementing a forensic recovery approach staff training program, almost all staff members believed that a recovery oriented approach to care would work with clients involuntarily detained. Furthermore, successful program implementation requires staff members to obtain an understanding of their roles and a clear description of program expectations in order to appropriately support consumers (Becker, 1998).

***H_2**: Staff members with less favorable attitudes will implement less recovery oriented services.*

Rationale: Embracing new practices in an existing organizational culture takes time and can act as a barrier to new principles and practices (Pascaris et al., 2008). The tendency of the dominant, existing culture is to go back to old practices. At times, staff that have been employed for extended periods of time at these facilities have become institutionalized in their thinking regarding staff roles and service delivery (Singh & Tosh, 2005). In order to overcome this barrier, providers' beliefs need to be reframed to incorporate the belief that their role is to serve the individual.

***H_3**: Administration and upper management will have more knowledge and more favorable attitudes as compared with lower level staff.*

Rationale: Leadership is a key component in successful recovery oriented service implementation (Becker et al., 1998). Directors are expected to guide the staff and overcome the barriers that impede change. Administrative staff should perceive themselves as support staff and provide the necessary resources for recovery (Singh & Tosh, 2005). Change needs to occur on all levels including the facilities mission, vision and values as well as the policies and procedures that support recovery. This process is facilitated by administrators. Additionally, individuals that have knowledge of recovery oriented care generally report a belief that recovery oriented care will work (Gudjonsson et al., 2010).

H_4: *Provider attitudes will be predicted by number of years in the field, type of job, education level, number of recovery oriented trainings, and whether or not that person has a mental illness or has a family member with a mental illness.*

Rationale: Many psychologists have been influenced by the stigma and hopelessness that are often associated with serious mental illness. Mental health professionals have been taught that serious mental illness requires long-term intensive care (Frese & Davis, 1997) and those who have been employed for extended periods of time at inpatient facilities may have themselves become institutionalized in their thinking (Singh & Tosh, 2005). However, mental health professionals that have personally experienced mental illness often reevaluate their earlier beliefs (Frese & Davis, 1997). Moreover, in order for significant progress to occur with mental health transformation, the concept of recovery must be clear and consistent (Davidson et al., 2005). Additionally, Gudjonsson et al. (2010) found that implementing staff training regarding recovery oriented care promotes

staff members' beliefs that a recovery oriented approach to care would work with clients involuntarily detained.

Chapter Four: Method

Design and design justification

This study combined both qualitative and survey methods to explore and gather information regarding recovery-oriented service implementation. Combining qualitative and quantitative methods to examine the process of recovery is useful because they enable the investigator to attend to different issues and prevent limiting the types of questions inquired, thus overcoming the inherent limitation in each one (Loveland et al., 2007).

Grounded theory methodology was utilized for the qualitative portion of this study. A structured interview format sought to explore the narratives of administrators to generate a theory regarding the complexities, staff knowledge and attitudes and barriers as well as strategies that facilitate recovery-oriented service implementation in the in-patient forensic system without diluting the integrity and complexity of the data.

This study utilized electronic data collection as an alternative to face-to-face interviewing. There are several benefits to this mode of communication. Web-based data collection is found to be more time and cost-effective to the researcher than face-to-face interviewing (Heiervang & Goodman, 2011; Shields 2003). Moreover, the participant's text is immediately available without the need for transcription (Shields, 2003). Additional benefits for the participant were found. Participants tended to write more extensively on electronic surveys, compared with paper and pencil surveys. Also when provided with the anonymity of an electronic interview, participants were less inhibited and censored in responding. Although participation rates for electronic data collection is

similar to face-to-face interviewing, survey completion rates are lower and selective participation bias is problematic (Heiervang & Goodman, 2011).

The investigators used the Recovery Knowledge Inventory (Bedregal et al., 2006) to probe knowledge and attitudes of the principles of recovery among staff. The Recovery Attitudes Questionnaire (Borkin et al., 2000) was utilized to assess attitudes of recovery. The RSA-R Administrator/Manager Version (O'Connell et al., 2007) was used to explore recovery practices in the facility. The qualitative and survey data were to be integrated to illuminate this phenomenon.

Participants

Participants in this study included all administrative and staff members willing to participate in this study at two inpatient forensic facilities in the United States. Staff members included program administrators as well as social workers, nursing staff, psychologists, psychiatrists, psych technicians, and other line staff. Participants in the qualitative portion of this study included eleven forensic hospital administrators and program directors from eleven participating facilities across the United States.

Inclusion Criteria

Participants were English speaking and literate at a high school reading level. Program directors and staff members had at least six months of work experience at the inpatient facility where the survey or structured interview was administered.

Exclusion Criteria

Participants that were not English speaking or who were not literate at a sixth grade reading level were excluded from this study. Additionally, individuals who did not

have at least six months work experience at the participating facility were excluded from the study.

Screening Procedures

Inpatient forensic facilities and contact information for facility administrators in the United States were identified and compiled by the investigator via on line resources such as the National Association of State Mental Health Program Directors (NASMHPD), and networking. A letter of inquiry was mailed to facility administrators.

Recruitment

A letter of inquiry was mailed by Dr. Petra Kottsieper to facility directors of inpatient forensic hospitals across the United States to garner interest in participating in this study. A follow-up call or e-mail was made to facility directors if no response was received within 3 weeks of mailing the letter. If facility directors responded that they were interested in this study, the investigator discussed the study with the facility director, and discussed the IRB application process. IRB applications were submitted at Philadelphia College of Osteopathic Medicine and at the facilities that required IRB approval to conduct research. The researcher and administrator determined how information regarding the study and questionnaire was distributed at each respective facility. Additionally, the initial contact letter requested that each facility interested in participation describe the facility departments including the number of individuals employed in each of the professional domains at the facility. The materials were mailed to each facility and the facility director and/or his/her staff distributed the materials to staff members as agreed upon by the hospital and investigator. Each survey had an

attached stamped and addressed envelope for survey participants to return the completed survey to the researcher.

A purposeful random sampling method was utilized to recruit hospitals simultaneously for this study's mixed method design. Thirty four facilities were randomly selected from a compilation of inpatient forensic facilities in the United States. Letters of inquiry were sent to the first thirty four randomly selected facilities. A minimum acceptance participation rate of five inpatient facilities was the anticipated requirement; however, only two hospitals responded. Several administrators that were contacted seemed unfamiliar with the recovery movement. Letters of inquiry were sent out once again to thirty four in-patient forensic facilities. In addition, recruitment efforts were altered to a snowball method. The required sample size was still not obtained. Letters of inquiry were sent via e-mail to 55 forensic directors for simultaneous recruitment for both the survey and qualitative portion of the study. Three more qualitative consents were obtained but no further interest in the survey research was received. Letters of inquiry were re-sent and follow-up phone calls were made. Finally, due to the lack of responses for the survey research, this researcher randomly selected ten hospitals to recruit via phone call and re-sent the letters of inquiry to the fifty five forensic directors via e-mail for recruitment for the qualitative portion of this study, only. An outline of recruitment efforts can be found in Appendix C.

Measures

For the survey portion of this study, a brief demographic questionnaire was given to participants to garner the following information: age; gender; ethnicity; mental illness in the family; geographic location of the facility; facility care level (long term;

intermediate; acute); job title; years of experience at the facility; years of experience working in the forensic system; number of trainings attended regarding recovery principles and services; and an open question "What does recovery oriented care mean to you?" The demographic questionnaire can be found in Appendix B. The investigators utilized the Recovery Knowledge Inventory (Bedregal et al., 2006), RSA-R Administrator/Manager Version (O'Connell et al., 2007), and Recovery Attitudes Questionnaire (Borkin et at., 2000) (provided in Appendix A).

The Recovery Knowledge Inventory (Bedregal et al., 2006) is a 20 item self-report measure designed to investigate knowledge of recovery. An example item is, "Only people who are clinically stable should be involved in making decisions about their care." The self-report items were rated on a five point Likert scale. Number one on the scale designated "strongly disagree" two designated "disagree", three designated "not sure", four designated "agree" and five designated "strongly agree."

The RSA-R Administrator/Manager Version (O'Connell et al., 2007) is a 36 item self-report measure to explore recovery activities with the last four items designated for administrators only. An example item is, "Program participants can change their clinician or case manager if they wish." An example administrator item is, "This agency provides structured educational activities to the community about mental illness and addictions." The self-report items were rated on a five point Likert scale. Number one on the scale designated "strongly disagree", and five designated "strongly agree." Participants also had the option to choose N/A, "not applicable" and D/K, "don't know."

Recovery Attitudes Questionnaire (Borkin et al., 2000) is a 16 item self-report measure. The self-report items were rated on a five point Likert scale. Number one on

the scale designated “strongly agree”; two designated “agree”; three designated “neutral”; four designated “disagree”, and five designated “strongly disagree.” An example item is “to recover requires faith.”

The qualitative design utilized in this study consisted of a structured interview format designed by the researcher. Research and interview questions were developed, based on a thorough literature review of recovery from both professional and consumer perspectives as well as the Recovery Oriented Systems Indicator Measure (Dumont et al., 2005), the Substance Abuse and Mental Health Services Administration’s (2005) national consensus statement on mental health recovery’s ten fundamental components of recovery, and the National Consensus Meeting on Person/Family-Centered Planning on wellness and recovery planning (Singh & Tosh, 2005). However, demographic information including race, age and gender was not obtained from administrators that participated in the qualitative interview.

Procedure

All relevant IRB approvals were obtained. Efforts were made to survey a minimum of five facilities. The investigators sought to survey several different program domains including administration, social work, nursing, psychology, psychiatry, psych technician and line staff in the participating facilities. Surveys were mailed to participating facilities and eight responses were obtained from two forensic state hospitals. Survey responses were mailed to the researcher via self-addressed, stamped envelopes. Two of the eight survey responses were not completed in full. Survey data were not analyzed due to minimal responses.

The investigator conducted structured interviews via Survey Monkey. Survey Monkey is a web-based tool utilized to create online surveys (Survey Monkey, n.d.). Participants received a link to access four questions on Survey Monkey. Each participant had a response field which allowed narrative entry. The internet protocol address was masked, which made the respondent untraceable, to protect against obtaining any identifying information. Eleven responses were collected over the course of nine months and printed from Survey Monkey for analysis. After the first four responses were received, the research team began analyzing the data. The research team consisted of two doctoral level students with a CBT orientation both pursuing a Psy.D in clinical psychology. They were referred to Corbin and Strauss (2008) for grounded theory instruction before data analysis began. Analysis continued throughout nine months. Emerging themes and concepts were derived from the narrative responses and an outline was produced by each team member. The research team then met and discussed the findings to validate the themes, categories and concepts. A final outline was produced via team consensus with four primary themes and several lower level concepts.

Data Analysis

This researcher utilized investigator and methodological triangulation to strengthen the study, support the conclusions, and strengthen the validity of the findings (Patton, 2002; Kazdin, 2003). For the qualitative portion of this study, the researcher utilized grounded theory methodology for data analysis. The investigator employed specific techniques suggested by Strauss and Corbin (1998) to augment the systematic and meticulous processes of comparison to culminate theory generation. Coding stages involved three levels: (a) open coding; (b) axial coding; (c) selective coding. The open

coding level refers to the analytic process through which concepts, properties and dimensions are identified through data (Stauss and Corbin, 1998; Patton, 2002). The axial coding involves the process of connecting categories to subcategories that revolve around relating properties and dimensions of an axis category. The selective coding process involves the detailed development of categories as well as core selection and integration of categories (Heath & Cowley, 2004). Line-by-line coding allows categories as well as their properties and relationships to emerge automatically and takes analysis beyond description (Strauss & Corbin, 1998; Patton). Thus, the theory is the detailed process fully conceptualized and integrated (Heath & Cowley, 2004).

Additionally, a coding team was enlisted to evaluate interpretation, conclusions, procedures as well as raw data and analytic strategies (Kazdin, 2003). Multiple investigators potentially address alternative interpretation, bias, and artifact as well as the reproduction of results. Coherence and agreement of interpretation were salient to evaluation of the findings (Kazdin, 2003).

The researcher planned to utilize t-tests and ANOVAs to test H_1 and H_3. The measures in this study were divided between high and low scores via a median split. Median split was to be used to create two groups, one scoring low and one scoring high. A Correlation was to be utilized to test H_2. Descriptive statistics to test hypotheses was to be utilized as well. Univariate frequency distributions and means were to be tabulated. Quantitative statistics were going to be conducted to analyze the research hypotheses and descriptive statistics used to describe the research sample and administrator/staffs' (a) knowledge; (b) attitudes; (c) skills. Survey findings and qualitative analyses were to be

integrated but data analysis did not occur for the survey portion of the study due to the lack of responses.

Chapter Five: Results

This study utilized grounded theory to explore emerging themes, derived from administrators' narratives about their experiences with Recovery-Oriented Services at their facility. Responses from eleven administers from in-patient forensic hospitals across the United States were obtained. The goal of this exploration was to garner information regarding the recovery transformation within the in-patient forensic hospital system.

Data Collection

Letters of inquiry were sent to 34 forensic facilities; in addition, 55 state forensic directors were invited to participate in this study. An additional ten administrators were contacted via phone call for only the qualitative portion of this study. Eleven administrators of in-patient forensic facilities were successfully recruited for the study and eleven qualitative interview responses were obtained. Two hospitals agreed to participate in the quantitative portion of this study. All forensic staff members were eligible to participate; however, only eight responses were obtained for both facilities combined. Data from those surveys were not reported in this study due to the limited amount of surveys obtained. Thus, hypotheses could not be tested. Efforts to obtain an appropriate sample size were impeded by obstacles encountered during recruitment and data collection efforts. Recruitment efforts are summarized in Appendix C. The thematic analysis of the eleven qualitative survey responses yielded 4 primary themes and several lower level concepts.

Data collection occurred over a period of nine months. In-patient forensic facility administrators were recruited either by phone call or by a recruitment letter sent either by

e-mail or by standard mail. Administrators were provided a link to Survey Monkey and asked to respond to four interview questions. Each participant had a response field which allowed narrative entry. The internet protocol address was masked, which made the respondent untraceable, to protect against obtaining any identifying information. The responses were collected and printed from Survey Monkey for analysis.

Data Analysis and Interpretation

Survey Monkey interview responses were collected and printed for analysis over the course of nine months. This researcher and a research team, consisting of two doctoral level students, began reading through and coding data after five of the eleven responses were obtained. The coding process continued throughout the collection of all eleven participant responses. Emerging themes and concepts were derived from the narrative responses and an outline was produced by each team member. Each individual team member produced themes and concepts before consulting other team members. The research team then met and discussed the findings. Themes and concepts were then determined by consensus. This process also helped to validate the themes, categories and concepts that emerged for each team member. A final outline was produced with four primary themes and several lower level concepts.

Descriptive Findings

The findings of this study emerged from the narratives collected from four interview questions. The four themes derived from analysis are consistent with the four interview questions and include implementation, obstacles and barriers, overcoming obstacles and facilitating strategies. Please see Appendix D for an outline of descriptive findings and the number of administrators that endorsed specific concepts. There are

several concepts that lead to higher level categories and each participant's narrative will be provided to exemplify the process of determining the findings. Pseudonyms will be utilized for the purpose of this study.

Implementation. Administrators were asked, "How are you implementing Recovery-Oriented Services at your facility?" Several concepts emerged and included: holistic treatment programming; consumer driven treatment; staff training and education; hospital mission and values; resources and involvement; multidisciplinary staff approach; and reduce coercive treatment.

A majority of the administrators described expanding existing programming to encompass values of recovery. A result of this effort seems to be a more holistic approach to treatment. This approach is evident in the following narratives.

> The Recovery-Oriented programming that has been generated by these committees includes Dialectical Behavior Therapy, Illness Management and Recovery and the Therapeutic Alternatives Program. Additional programming that is recovery-oriented include our vocational rehabilitation program, occupational therapy, educational classes, horticultural therapy, art therapy, music therapy, peer support program, substance abuse program and recreational programming. (Al)

> We use a treatment mall approach to groups; we redesigned our vocational activities which have a strong emphasis on assisting clients to develop work skills while in the hospital that can transition to community jobs; we have added alternative therapies to treatment i.e. reiki, massage, yoga, aromatherapy,

> occupational therapy, nursing kardex that identifies triggers and interventions. (Carol)

> The hospital as a whole operates treatment malls.[1] Groups address a wide range of issues. These issues include basic concentration and cognitive organization, substance abuse, relapse prevention, health and wellbeing, reintegration into the community settings, understanding psychiatric symptoms, medication education and WRAP (Wellness Recovery Action Planning). (Nick)

Several other administrators also discussed expanding treatment to include values of recovery that reflect holistic treatment. For instance, Holly stated, "We implemented a work program to give them valued roles", and Lynn reported, "All of our programs are evidenced-based or promising practices, each with a recovery foundation." Tom reported "Treatment providers utilized recovery principles in groups such as Illness Management and Recovery" and Jess discussed recovery-oriented and trauma informed services implementing work groups which augmented, "boredom busting leisure activities and the other of which will be piloting a comfort room."

[1] Treatment malls utilize centralized treatment programming for education and psychosocial skills training (Ballard, 2008). See Ballard, Benefits of Psychosocial Rehabilitation Programming in a Treatment mall for a more detailed description.

Christine reported “We have a multifaceted strategic plan centered around recovery”, and Jeff responded “co-occurring disorders groups” and “we also have AA volunteers that come in and hold weekly sessions.” Finally Kelly discussed generating new treatment to embrace recovery and responded, “We also have an active vocational program which serves our forensic patients.” Although many of the administrators discussed incorporating many different types of groups to transform their services to embrace recovery, the additional groups seemed to be generated to better meet the needs of consumers and promote the essence of holistic care.

Consumer Driven Treatment was also an important concept among administrator narratives. In general, administrators reported consumer participation in some aspect of service implementation. The level of consumer participation varied among treatment programs and ranged from fundamental involvement, such as involvement in treatment planning to involvement on hospital committees and policy making. For instance, Ann reported “On admission screening, patients are being asked what they would like to work on.” Kelly stated “We involve patients in the treatment planning process and emphasize strengths”; “We have patient advocacy groups led by peer advocates”, and “We have hired two peer advocates.” Christine reported “use of peer specialists and client advocates (all are consumers of services” as well as “consumer-run councils” and “consumer participation on executive teams.” Al reported part of the recovery-oriented programming at their facility includes a “Peer Support Program” and Nick stated, “Other than insanity acquittees, most forensic patients are involved in the mall program, serving the admission service.” Jess reported “We’ve established a Recovery Care Workgroup, to which we’ve recently added patients as members.”

Many administrators identified consumer involvement not only in the decision making for their own treatment but also in decision making regarding program implementation and policy making. Additionally, several of the administrators had former consumers take part in the care of consumers currently on the in-patient unit. Several of the administrators described consumer involvement in their narratives:

> We encourage clients to be group co-facilitators, clients who are discharged come back to be guest speakers at groups. We have peer support assigned to each unit; we involve clients in process action teams with staff to look at policy changes. We involve clients in process action teams with staff to look at policy changes; we have clients on our hospital advisory board (governing board). (Carol)

> We then went about staffing the unit based on the patients needs rather than on old staffing patterns. We purposely had patients more involved in their own treatment- -having more input on what groups/services they needed/ did not need. We had them involved in deciding the meal for a monthly meal and then preparing it. We had patients as part of the hiring panel when we hired new staff. We started giving patients more choice into their discharge plans-but also accepting responsibility for the choices they made. (Holly)

Staff Training and Education also appeared to be an integral strategy to implementing recovery-oriented care. Holly reported "We did a lot of work/training with staff on developing a collaboration mindset versus a parental mindset" and Jess reported "We've had a number of recovery-based and trauma informed CE presentations."

Additionally, several of the administrators describe training for staff at various levels of employment within the organization. Ann stated "Office of Behavioral Health staff attend workshops." Tom reported "The concept of recovery and principles of recovery are provided to new employees as part of the initial orientation and training."

Some administrators identified the fact that their hospital mission and values incorporated recovery-oriented care at their facility. Lynn reported "Our hospital's mission is recovery oriented" and Jess reported "We've rewritten our hospital values and are in the process of implanting a Cause for Applause program to recognize staff who best exemplify our values." Additionally, Christine identified utilizing recovery principles to hire new staff at their institution.

Consumer involvement in the community was also recognized as a strategy to implement Recovery-Oriented care. Carol reported "Clients work in the community while still clients." Several other administrators described community resources and community involvement by consumers as a part of treatment at their facility in the following narratives:

> We felt to meet their recovery needs we needed more staff designated to take them into the community to establish community resources. What we discovered was 80% of our patients had the privilege to go into the community (either escorted or unescorted) but because of our staffing they were rarely getting to actually use the privilege. We found we were able to get more NGRIs conditionally released. (Holly)

> Educate patients about recovery-oriented services that are being developed in the community, including housing supports, ACT (Assertive Community Treatment) and FACT (Forensic Assertive Community Treatment) teams in some urban areas and how to contact NAMI. We are also developing treatment plans that emphasize continued treatment in the community and send discharge plans to community providers. (Ann)

> We are developing a community resource center, which will make community living choices—residential, recreational, social, spiritual—more salient to inpatients through computer access to the internet, periodicals, maps, bus schedules etc. We have active liaisons with community providers, including single point of access meetings with local providers. (Kelly)

A multidisciplinary staff approach to treatment was identified as a strategy to implement Recovery-Oriented Services. Administrators described various disciplines involved in treatment, based on the necessity of the consumer. Carol reported, "We added an occupational therapist to the staff who works with clients on sensory interventions; our nursing kardex now identifies triggers and what interventions work for each client." Jeff reported, "We have three chemical dependency counselors" and "AA volunteers." Additionally, the various disciplines involved in treatment are based upon the consumers needs. Holly stated, "We then went about staffing the unit based on client needs and not old staffing patterns" and "We felt to meet their recovery needs, we needed more staff designated to take them into the community to establish community resources;

they needed less nursing and primary nursing care; we felt they needed more psychology and social work time."

Although the reduction of coercive treatment is an important aspect of recovery-oriented care, it was a novel concept specified by administrators. Carol reported, "We did drill downs on all the high end users of coercive treatment." Christine responded to implementing recovery practices by a "reduction of seclusion/restraint and other coercive procedures and practices."

Obstacles and Barriers. Administrators were then asked the question, "What are the obstacles and barriers when implementing Recovery-Oriented Services?" The concepts that emerged from their narratives included staff and administrator attitudes and knowledge, consumer challenges, legal and security concerns, and limited resources.

Staff Attitudes and Knowledge were indicated as obstacles to applying recovery services to practice. Carol responded, "Staff that have worked at the facility for years needed to be educated in alternative interventions rather than to do things the way they always have" and Holly reported, "There was some initial staff resistance due to fears patients would have too much power." Holly also stated, "We always had to combat reverting to a more medical model of treatment (we know best)" and "We had/have issues with defining boundaries both for staff and patients." Tom responded, "Making sure all staff who work with patients understand and utilize recovery-based principles in their daily interactions with patients" and Jess identified, "changing others thinking on providing these services" as an obstacle.

Some of the administrators identified the attitudes of staff in various employment domains as barriers. Christine stated, "Leadership must buy in" and Jess stated the following:

> One of our unions' central offices insists on referring to our patients as prisoners. We've been mandated to accept staff from prisons that are closing. Most of our clinicians were not trained with a recovery focus. Line staff feels burdened by yet another set of expectations. We battle stigma-hopeless beliefs about mental illness shared by staff and patients. (Jess)

Additionally, Lynn identified the challenge of maintaining a recovery attitude when working with a specific type of consumer. "Challenges include: holding out hope and recovery for individuals who have committed serious crimes and who will be confined for prolonged periods; influencing, training, and supervising direct care staff to maintain a recovery orientation even in the face of very serious behavioral challenges." (Lynn)

Holly and Kelly identified Consumer Challenges as a barrier to implementing Recovery-Oriented Services. The focus here changed from the responsibility of staff to maintain recovery attitudes and recovery knowledge to the consumer's difficulty in treatment and perceived behavioral challenges. In both situations, the administrators seem to be identifying the individual consumer as the barrier to Recovery-Oriented care. Holly reported, "Patients unfortunately began to view privileges as rights and the more freedom we gave them the more demanding some of them became." Kelly described the following consumer challenges in their narrative:

> Our hospital serves mainly treatment refractory patients who continue to be symptomatic despite treatment with antipsychotic medications and mood

> stabilizers. These continued symptoms hinder discharge to community settings without additional supports. Other patients have been in the hospital so long, they are very fearful of leaving. As a result they avoid participating in activities that they perceive as leading to discharge. (Kelly)

Legal and security concerns were also indicated as obstacles that hinder the delivery of Recovery-Oriented Services to daily practice. Al reported, "We are unable to provide community visits or allow free access to the facility by outside visitors due to safety and security needs inherent in the population" and Nick reported, "Individuals facing active legal situations are not eligible for community groups and after mall hours groups due to security requirements." Additionally, security and legal concerns were indicated as obstacles to maintaining consumer involvement in treatment. Christine reported, "Consumer involvement in a maximum/intermediate forensic setting is always a challenge" and Lynn reported, "interfacing with the legal system and post-discharge monitoring requirements while trying to support individuals' recovery plans." Furthermore, Holly identified the dangers of implementing Recovery-Oriented Services as a barrier: "We had to accept this new model came with some risks (more opportunities for elopement, self-harm, relapse into substance misuse)."

In general, administrators recognized limited resources as a barrier. They described a lack of resources regarding staff time, money and available supports. Several administrators described limited resources in their responses: "We lack resources, especially money and time; we're pulled in many different directions and seem always to be putting out fires rather than implementing long-term strategies (Jess)"; "some financial constraints, for example I would like to have more OTs on staff (Carol)"; "sometimes

staff levels do not permit holding the mall for a half a day due to the numbers of other demands on staff member time (e.g. transports to appointments, safety monitoring)" (Nick); "a traditional lack of said services and fragmented care following discharge; transportation issues were a major difficulty (Ann); and "lack of residential housing options for patients; assistance with medication administration for newly discharged former inpatients; without safe housing many patients who could live outside the hospital continue to be hospitalized." (Kelly) Jeff simply stated, "cost."

Overcoming Obstacles and Barriers. In the next part of the interview, the administrators were asked, "What are the strategies you have used to overcome those barriers?" The concepts that emerged included the following: involvement and communication, public relations, education and training, focus on the positive, and no solution.

Administrators commonly highlighted staff, consumer, family and community involvement and communication as approaches to facilitate recovery implementation, despite the obstacles. Often involvement was important to effectively communicate recovery strategies, in order, ultimately, to permeate barriers.

> We had unit staff sit in on team meetings so they could better understand the rationale for some decisions. We tried to help patients understand how they were perceived when they appeared entitled and the negative consequences of acting in that manner. We did a lot of work with the community-explaining why we did things the way we did. We tried to empower the unit staff so they wouldn't fight for power with the patients. (Holly)

In addressing issues of staff resistance regarding security concerns and change, Al stated, “Communication is the key in both situations and find it helpful to explain the rationale for new initiatives and get buy-in before implementing significant changes.” Lynn reported, “involving clients in all aspects of our organization” and Christine reported, “The team meets once a month and has staff from all levels of the facility and consumers involved.” Jess described utilizing a SAMHSA technical assistance visit to improve recovery implementation and they suggested, “increasing staff and patient involvement; effective leadership; champions on each unit.”

Ann spoke about involvement from both the family and community: “Active participation by families is encouraged, as is contact with families while patients are in the hospital’ and “ACT and FACT teams go to the patients in the community.” Additionally, Kelly indicated increased involvement with more non-compliant consumers and their families: “We provide intensive, individualized work with the more treatment refractory patients and their families.”

Leadership and community interactions were identified as important components to recovery-oriented care for successful implementation to occur at the in-patient facility. Therefore, public relations were essential. Holly spoke of public relations throughout her narrative: “We did a lot of one on one encouragement of the communities and used our personal relationships to effect change; “I had to do a lot of buffering from the administration to not impede the work of the treatment team”; and “I did a lot of PR work.” Jess reported “effective leadership, etc.; leaders have committed to, as our governor would say, relentless positive action” and Jeff reported “continue to dialogue

with our administration" and "presenting to stake-holders and the need for these services based on population statistics."

Formal and informal education and training were also identified as integral aspects of overcoming obstacles to implementing Recovery-Oriented Care. Carol reported "Educate, educate, and educate staff. Bringing outside "experts" whom they tend to pay attention to more than people they work with." Holly reported "We did a lot of informal teaching/coaching with our staff" and participant six stated, "influencing, training, and supervising staff of all levels to maintain a recovery focus." Jess discussed utilizing education and training in various forms, stating, "providing education to staff and patients in different forums" and Tom demonstrated that very idea in his narrative: "The hospital utilizes brief training sessions with small groups of direct care staff. Also, mandatory online trainings are provided monthly, and recovery principles are included in these trainings at times."

A novel concept was to focus on the positive. Carol reported, "pointing out the positive results and the progress that clients have made both within the hospital as well as in the community" as a means to overcome barriers. Holly stated, "showing how far our unit came after we changed (increased discharges, shorter LOS)."

An interesting notion was raised by some administrators when they identified the obstacles and barriers of recovery as insurmountable or something that they have not yet attempted to overcome. Primarily, the barriers to which the administrators feel that there is no solution revolve around legal and security concerns. Al stated, "No getting around the security issues. We need to keep people safe in our building and are ever mindful of the serious consequences of security breaches." Nick described this idea as well:

> We have not attempted to overcome these barriers. State regulations permit some persons to access increased privileges[in order] to attend groups in other areas of the hospital on a limited basis, but off grounds privileges seem to exceed the court's willingness to approve community privileges for someone who was not permitted bond following arrest. It seems a bit unrealistic to us as well, given that we must think about treatment and safety security in forensic settings. (Nick)

Additionally, Carol discussed resistant staff in her narrative and stated, "If all else fails and they just don't get it, encourage them to work in another setting." Although, this administrator does not relate the concept of "no solution" to legal and security concerns, the idea that the barrier is insurmountable was portrayed.

Facilitating Strategies. The final question administrators were asked was, "What are the strategies that facilitate Recovery-Oriented Services?" This question focused not only on what administrators are doing to implement Recovery-Oriented Services but also what they have found to be the most effective. The concepts that were identified included mission statement and values, staff training and supervision, consumer involvement in treatment and policy, and discharge readiness.

The hospital's mission statement and values demonstrated by staff was recommended by administrators to facilitate Recovery-Oriented Services. Carol stated "has to be supported by all levels of the organization and part of the hospital's mission and goals" and Lynn reported "strong mission statement and values that are truly integrated in operations" as strategies that assisted recovery in their facilities. The importance of exhibiting recovery values in practice was also discussed by Tom

"emphasizing the philosophy of recovery in staff-patient interactions" and Jess "visible, consistent, enthusiastic participation by leadership."

Lynn identified **"**training and supervision of staff" as an effective strategy utilized to promote recovery. Several other administrators agreed. Nick "sent facilitators for WRAP training and other recovery-oriented training" and Holly engaged in "informal teaching/coaching" with staff. Tom reported that they "focus on recovery at new employee orientation" and integrate "periodic training to existing staff."

Consumer Involvement in Treatment and Policy was another concept discussed by administrators in their response narratives. Al identified the importance of clients' "better understanding of the issues that led to their hospitalization(s) and begin to take ownership of their recovery." Carol described involvement with both current and former consumers.

> I meet monthly with the advocates to hear how we are doing. I also hold a client forum monthly. I use that feedback to make changes in policies as well as attitudes. We have a committee made up of former consumers, family members, and community providers that review client grievances, all our policies, and quality indicators to make suggestions for improvements. (Carol)

Ann felt "involving patients as active participants in their care and recovery" facilitates recovery as well as "giving a choice in the kinds of care delivered that is respectful of individual beliefs, patient strengths and peer support systems." Lynn reported "involving clients not only in their own treatment and recovery processes, but also in policy development and various committees" and Jess stated "patient involvement" to effectively implement recovery. Additionally, Christine had a similar experience of

success with a “multi-level staff and consumer involvement” and “consumer involvement in all aspects of their care.”

Furthermore, Recovery-Oriented Services incorporated aspects of discharge planning and readiness in in-patient treatment programming. Thus, services do not end in the hospital but support the consumer in the community as well.

> Our mental health clinics send personnel to the facility to meet with persons who were admitted from their catchment area in order to assess needs upon discharge and to develop plans. Several of our mental health clinics have forensic discharge planners who not only meet with their clients at the hospital but also serve them in the jail and facilitate services being received when the legal situation has been resolved. (Nick)

Al identified discharge readiness as important to “avoid future relapses, re-incarcerations and re-hospitalizations.” According to Kelly, “Probably the strategy that is most essential is to provide adequate supportive housing beds in the community” and “such individuals can also benefit from drop in centers which provide recreational and social supports to them.” Additionally, Jess described “health, home, purpose, community”, as aspects of treatment programming that facilitated a recovery orientation. Thus, care does not merely incorporate strategies to help consumers transition from in-patient care but also integrates a focus to improve the consumer’s quality of life upon discharge.

Chapter Six: Discussion

A dialectic exists between the criminal legal system and recovery focused mental health treatment, derived from the federal initiative, focused on civil rights. The tension is consequent upon the legal system's concerns with public safety and with punitive actions through incarceration (withdrawing certain freedoms), whereas recovery focused mental health promotes the maintenance of civil rights, individuality and treatment. To synthesize these divergent systems on a micro level and successfully apply both legal and recovery expectations in practice can be quite challenging.

Efforts are being made to implement Recovery-Oriented Services in in-patient forensic hospitals. It appears that the most common strategy to initiate recovery services in treatment programs is to expand treatment program options for consumers. This is congruent with SAMSHA's (n.d) guiding principles for recovery, indicating that services should be holistic. Although, offering new holistic and alternative treatment programming was typically generated, this occurred to different degrees in the various facilities. Some hospitals made many program changes to reflect the values of recovery, but others made rather small changes that some facilities may have had in place before the recovery transformation. Additionally, even though these changes present a veneer of Recovery-Oriented Services, this does not necessarily mean the facility functions as a Recovery-Oriented Program. Many more complex changes need to occur within the system to encompass Recovery-Oriented care.

For instance, administrators indicated that consumers must be involved in the development of new treatment programming and drive the treatment process by contributing to individual treatment planning and delivery, as well as to policy and

leadership within the forensic in-patient service system. This was consistent with the literature indicating that control and self-determination are central themes in recovery (Jacobson & Greenley, 2001; Frese & Davis, 1997; Schiff, 2004; Tower, 1994; Davidson et al., 2006). Current and former consumers are envisioned by administrators as participating in this process and are an integral aspect of recovery care. Treatment must be individualized to meet the needs of the consumers and are primarily determined by the consumer. Consumers have the right, as is feasible, to determine their lives in the present moment and in the future. Davidson et al. (2006) suggest that it is unreasonable and unethical to require individuals with serious mental illness to become symptom-free in order to exercise this right. This right is to be taken away only if there is a clear basis grounded in law and controlled by the criminal justice system (Frese & Davis, 1997; Davidson et al., 2006). Thus, the reduction of coercive treatment in in-patient forensic programming is essential.

Additionally, administrators recognized that treatment should not end at discharge. It needs to be a continuous process that transitions the consumer into the community and supports the consumer in life. Many of the administrators indicated that access to community resources and consumer community involvement was an important aspect of in-patient programming. This is congruent with the essence of recovery. Recovery does not occur in a vacuum but with encouragement, particularly encouragement to participate in the world (Ralph, 2007). The activities and roles that individuals choose to participate in are less important than the personal meaningfulness and their perceived value to the community (Davidson et al., 2007).

In some hospitals, the mission was changed to incorporate the values of recovery and these values were applied to practice. It was suggested that recovery values transformed to practice not only occur with direct care staff, but also in all staff domains, including leadership, administration, and within the family and community. This is consistent with the external constructs of recovery; one of the primary components of this is the presence of people who believe, support, and encourage the primary principles of recovery (Frese & Davis, 1997; Jacobson & Greenley, 2001; Davidson et al., 2006). Thus, a multidisciplinary approach to meet the needs of the consumers is necessary. However, some administrators identified the fact that many staff members were not knowledgeable regarding recovery values and were resistant to change. It was crucial to shift staff attitudes and increase recovery knowledge; thus administrators indicated staff training and education was imperative to the recovery transformation process.

In addition to staff resistance and lack of knowledge, there were several barriers highlighted by administrators that prevented the successful implementation of Recovery-Oriented Services. Limited resources, including money and staff time, were among the most common obstacles. This was problematic due not only to the lack of resources to provide holistic care, but at times was also a barrier to consumers actually receiving traditional care on the unit and in the community. Moreover, legal and security concerns conflicted with Recovery-Oriented Services in similar ways. Legal restrictions and safety were identified as obstacles to recovery primarily by limited program access due to restrictions of movement on units and by limited community access as well.

The last barrier identified by administrators in the implementation of Recovery-Oriented Services was consumer challenges. In this situation, the consumer is identified as the barrier. Difficulty in treatment, such as severe chronic mental illness and behavioral problems, were specifically indicated as the barriers to recovery care. However, this idea is antithetical to the heart of the recovery transformation. Recovery is a process that does not require the reduction of symptoms or a disability-free end point to maintain basic civil rights such as making personal choices, pursuing individual hopes and goals, establishing gainful employment, as well as to choosing and participating in activities that are personally meaningful (Davidson et al., 2005; Ralph & Corrigan, 2007; Davidson et al., 2006). Redefining how to conceptualize work with severe mental illness and behavioral problems, as opposed to the traditionally medically driven service system in which "we know best", is essential for successful implementation of recovery transformation. Recovery emphasizes the fact that consumers have important knowledge regarding their needs and interests that are equally if not more important than that of the professionals (Tower, 1994).

Staff training and education is a strategy prevalent among administrators to overcome obstacles. Training and education are particularly tangible solutions to lack of staff knowledge and staff resistance. It may even be utilized as a means to learn how to put recovery values to practice when working with consumers, particularly "challenging" consumers.

Consumer, staff, family and community involvement and communication were also strategies to overcome resistance and were often utilized to gain buy-in before changes were made. Transparency was identified as an essential component of this

process. Moreover, public relations, obtaining buy in from all levels of staff, especially community and leadership, was noted as important.

This endeavor included communication, often pointing out the positive progress made after implementing Recovery-Oriented care. Public relations was also important when justifying the continued need of Recovery-Oriented programming and prevented leadership from inhibiting direct-care staff from practicing Recovery-Oriented Services on the unit.

The strategies that seem the most effective in facilitating Recovery-Oriented Services were as follows: the hospital mission statement and values; staff training and supervision; consumer involvement in treatment and policy, and discharge readiness. Recovery values were described as prevalent throughout the entire service system and change was encouraged through training and supervision. The transformation to recovery was expected to occur on all levels. This particularly included allowing and believing the consumers have the right and the ability to determine their individual needs and policies regarding future services for themselves and the care of others. Additionally, continuity of care was deemed to be of importance and was envisioned to extend to the community. Thus, these strategies targeted the more complex goals of recovery as an ongoing process, and not as a superficial engagement of recovery. Strategies were noted in order to promote meaningful changes to help improve the quality of life for consumers.

Although, several strategies to overcome the obstacles and barriers and to facilitate Recovery-Oriented Services were discussed, several of the barriers and obstacles identified were not addressed. For instance, some of the administrators felt that there were no solutions to the legal and security concerns, and continued staff resistance

after training and education efforts were made. Several admitted never thinking about solutions to the barriers and felt it impeded positivity among staff. This remains a dialectic that continues to be unsynthesized in practice. Perlin (1991) suggests that the nature of forensic relationships is, inherently, power imbalanced. Forensic mental health professionals are not intervening for therapeutic purpose but in response to several external entities such as the litigation, attorney, court, prosecuting agency, and the state mental health facility itself. Thus, the presence of a third party necessitates an understanding that any forensic relationship as containing a power imbalance due to the dangers of dual loyalties or dual agentry. Greenberg and Shuman (2007) suggest that staff members should not attempt to fulfill dual roles for the same consumer. Greenberg and Shuman (2007) stated, "This is not because they are not competent to do so. This is because, professionally, the tasks are irreconcilably mutually exclusive." Additionally, the American Psychology-Law Society, Standard 6.02 Multiple Relationships, and the American Academy of Psychiatry and the Law, Standard IV Honesty and Striving for Objectivity, specifically admonish against dual relationships in forensic settings.

Limitations

This study had several significant limitations. This researcher was unable to utilize theoretical sampling, an important aspect of elaborating analysis according to Corbin and Strauss (2008), due to recruitment problems. The study used the same four questions throughout data collection and analysis, despite new questions that emerged from the data. These questions could not be explored because the study was designed in such a way that respondents could not be identified. This study also lacks conceptual saturation; thus it has not developed the themes and categories sufficiently and is unable

to illuminate the reasons for variation in responding among administrators (Corbin and Strauss, 2008).

This study had a small sample size and lacked sufficient depth regarding interview questions and data collection due to recruitment problems. The researcher originally anticipated obtaining both qualitative and quantitative data. The quantitative data was not utilized in the study due to limited survey responses. Given the fact that the qualitative portion of the study was not designed as a standalone study, it was brief and did not comprise the typical length of in-depth interview questions. Additionally, no demographic information was obtained from the qualitative participants. Thus the findings of this study may not be generalized to other administrators because their experiences may be different.

It is possible that administrators responded only if they had knowledge of Recovery-Oriented Services and had implemented those services at their facilities. Facilities that are not knowledgeable and/or not implementing Recovery Services may be less likely to respond. Thus the sample may be biased. Additionally, significant barriers that prevent facilities from providing recovery practices in in-patient forensic facilities could have been overlooked.

Moreover, many state hospitals only allow research to be conducted only with employees currently working in or being affiliated with that service or state system. This may threaten a researcher's ability to be objective and skew the sample that this researcher was able to obtain. Thus this sample could be biased and not accurately reflect recovery transformation efforts in forensic settings across the United States.

The study sample was limited because the quantitative study of Recovery-Oriented Services could not be conducted. The experience of practicing Recovery-Oriented Services with consumers may vary greatly among staff in various domains, particularly with those working directly with consumers. Additionally, this study did not account for various levels of mental illness, criminality and behavioral problems among consumers on the in-patient unit. Recovery-Oriented Service implementation, barriers and obstacles to implementation, and facilitating strategies may differ among diverse consumers.

Future Directions

This study sought to explore the recovery transformation in in-patient forensic service systems. Due to significant recruitment problems, often related to barriers in conducting research in in-patient forensic facilities, more in-depth sampling is needed for future research in this area. A larger sample, with more consistent access to forensic staff, can provide valuable information regarding variations in response narratives and lack of saturation prevalent in this study.

This study did not focus on whether or not strategies for implementation vary among different forensic populations. Future studies may explore implementation strategies and barriers for different levels of mental illness, behavioral problems and severity of crime. Research may also focus on variations in diverse in-patient forensic environments such as in different regions of the country, urban and rural areas, and socioeconomic status.

Other research may seek to describe if and how Recovery-Oriented Services can be incorporated in practice, yet maintain legal stipulations and the safety and security of

the institution. Research may focus on facilitating strategies for consumers with various charges, history and high risk of violent offending and long term hospitalizations. Additionally, Perlin (1991) identifies the importance of consideration of the mental health professional's role and whether or not he or she can be an agent of both the client and the third-party institution.

Conclusion

Although the recovery transformation has been a slow process in the forensic service system, efforts are being made. Implementation strategies, as well as obstacles to recovery practices have been identified. Facilitating strategies to overcome barriers have been explored, but this exploration should persist in future research. Although unique challenges continue to exist within the forensic system, applying recovery practices with all consumers is the ultimate goal.

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Appendix A

RECOVERY KNOWLEDGE INVENTORY

Please rate the following items on a scale of 1to 5:

1	2	3	4	5
Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree

1.	The concept of recovery is equally relevant to all phases of treatment.	1	2	3	4	5
2.	People receiving psychiatric/substance abuse treatment are unlikely to be able to decide their own treatment and rehabilitation goals.	1	2	3	4	5
3.	All professionals should encourage clients to take risks in the pursuit of recovery.	1	2	3	4	5
4.	Symptom management is the first step towards recovery from mental illness/substance abuse.	1	2	3	4	5
5.	Not everyone is capable of actively participating in the recovery process.	1	2	3	4	5
6.	People with mental illness/substance abuse should not be burdened with the responsibilities of everyday life.	1	2	3	4	5
7.	Recovery in serious mental illness/substance abuse is achieved by following a prescribed set of procedures.	1	2	3	4	5
8.	The pursuit of hobbies and leisure activities is important for recovery.	1	2	3	4	5
9.	It is the responsibility of professionals to protect their clients against possible failures and disappointments.	1	2	3	4	5
10.	Only people who are clinically stable should be involved in making decisions about their care.	1	2	3	4	5
11.	Recovery is not as relevant for those who are actively psychotic or abusing substances.	1	2	3	4	5
12.	Defining who one is, apart from his/her illness/condition, is an essential component of recovery.	1	2	3	4	5
13.	It is often harmful to have expectations that are too high for clients.	1	2	3	4	5
14.	There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.	1	2	3	4	5
15.	Recovery is characterized by a person making gradual steps forward without major steps back.	1	2	3	4	5
16.	Symptom reduction is an essential component of recovery.	1	2	3	4	5

17. Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.	1	2	3	4	5	
18. The idea of recovery is most relevant for those people who have completed, or are close to completing, active treatment.	1	2	3	4	5	
19. The more a person complies with treatment, the more likely he/she is to recover.	1	2	3	4	5	
20. Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals.	1	2	3	4	5	

RSA-R

Administrator/Manager Version

Please circle the number below which reflects how accurately the following statements describe the activities, values, policies, and practices of this program.

1 2 3 4 5

Strongly Disagree Strongly Agree

N/A= Not Applicable
D/K= Don't Know

1. Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.	1	2	3	4	5	N/A	D/K
2. This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).	1	2	3	4	5	N/A	D/K
3. Staff encourage program participants to have hope and high expectations for their recovery.	1	2	3	4	5	N/A	D/K
4. Program participants can change their clinician or case manager they wish.	1	2	3	4	5	N/A	D/K
5. Program participants can easily access their treatment records if they wish.	1	2	3	4	5	N/A	D/K
6. Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	1	2	3	4	5	N/A	D/K
7. Staff believe in the ability of program participants to recover.	1	2	3	4	5	N/A	D/K
8. Staff believe that program participants have the ability to manage their own symptoms.	1	2	3	4	5	N/A	D/K
9. Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	1	2	3	4	5	N/A	D/K

10. Staff listen to and respect the decisions that program participants make about their treatment and care.	1	2	3	4	5	N/A	D/K
11. Staff regularly ask program participants about their interests and the things they would like to do in the community.	1	2	3	4	5	N/A	D/K
12. Staff encourage program participants to take risks and try new things.	1	2	3	4	5	N/A	D/K
13. This program offers specific services that fit each participant's unique culture and life experiences.	1	2	3	4	5	N/A	D/K
14. Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	1	2	3	4	5	N/A	D/K
15. Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	1	2	3	4	5	N/A	D/K
16. Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	1	2	3	4	5	N/A	D/K
17. Staff routinely assist program participants with getting jobs.	1	2	3	4	5	N/A	D/K
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	1	2	3	4	5	N/A	D/K
19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).	1	2	3	4	5	N/A	D/K
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	1	2	3	4	5	N/A	D/K
21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	1	2	3	4	5	N/A	D/K
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	1	2	3	4	5	N/A	D/K
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	1	2	3	4	5	N/A	D/K
24. People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	1	2	3	4	5	N/A	D/K
25. People in recovery are encouraged to attend agency advisory boards and management meetings.	1	2	3	4	5	N/A	D/K

26. Staff talk with program participants about what it takes to complete or exit the program.	1	2	3	4	5	N/A	D/K
27 Progress made towards an individual's own personal goals is tracked regularly.	1	2	3	4	5	N/A	D/K
28. The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	1	2	3	4	5	N/A	D/K
29. Persons in recovery are involved with facilitating staff trainings and education at this program.	1	2	3	4	5	N/A	D/K
30. Staff at this program regularly attend trainings on cultural competency.	1	2	3	4	5	N/A	D/K
31. Staff are knowledgeable about special interest groups and activities in the community.	1	2	3	4	5	N/A	D/K
32. Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	1	2	3	4	5	N/A	D/K
Separate Section for Administrators Only							
33. This agency provides formal opportunities for people in recovery, family members, service providers, and administrators to learn about recovery.	1	2	3	4	5	N/A	D/K
34. This agency provides structured educational activities to the community about mental illness and addictions.	1	2	3	4	5	N/A	D/K
35. This agency provides a variety of treatment options for program participants (e.g., individual, group, peer support, medical, community –based, employment, skill building, employment, etc.).	1	2	3	4	5	N/A	D/K
36. Groups, meetings, and other activities are scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	1	2	3	4	5	N/A	D/K

RECOVERY ATTITUDES QUESTIONNAIRE (RAQ-16)

Recovery is a process and experience that we all share. People face the challenge of recovery when they experience the crises of life, such as the death of a loved one, divorce, physical disabilities, and serious mental illnesses. Successful recovery does not change the fact that the experience has occurred, that the effects are still present, and that one's life has changed forever. Rather, successful recovery means that the person has changed, and that the meaning of these events to the person has also changed. They are no longer the primary focus of the person's life (Anthony, 1993).

We are interested in measuring your beliefs about the concept of recovery from mental illnesses.
Please read each of the following statements and using the scale below mark the rating that most closely matches your opinion.

SA	A	N	D	SD
Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**

1.	People who are in recovery need the support of others.	**SA**	**A**	**N**	**D**	**SD**
2.	Recovering from mental illness is possible no matter what you think may cause it.	**SA**	**A**	**N**	**D**	**SD**
3.	A good understanding of one's mental illness helps in recovery.	**SA**	**A**	**N**	**D**	**SD**
4.	To recover requires faith.	**SA**	**A**	**N**	**D**	**SD**
5.	Recovery can occur even if symptoms of mental illness are present.	**SA**	**A**	**N**	**D**	**SD**
6.	People in recovery sometimes have set backs.	**SA**	**A**	**N**	**D**	**SD**
7.	People differ in the way they recover from a mental illness.	**SA**	**A**	**N**	**D**	**SD**
8.	Recovering from mental illness can occur without help from mental health professionals.	**SA**	**A**	**N**	**D**	**SD**
9.	All people with serious mental illnesses can strive for recovery. .	**SA**	**A**	**N**	**D**	**SD**
10.	People who recover from mental illness were not really mentally ill in the first place.	**SA**	**A**	**N**	**D**	**SD**
11.	The recovery process requires hope.	**SA**	**A**	**N**	**D**	**SD**
12.	Recovery does not mean going back to the way things used to be.	**SA**	**A**	**N**	**D**	**SD**
13.	Stigma associated with mental illness can slow down the recovery process.	**SA**	**A**	**N**	**D**	**SD**
14.	Recovering from the consequences of mental illness is sometimes more difficult than recovering from the illness itself. .	**SA**	**A**	**N**	**D**	**SD**
15.	The family may need to recover from the impact of a loved one's mental illness.	**SA**	**A**	**N**	**D**	**SD**
16.	To recover requires courage.	**SA**	**A**	**N**	**D**	**SD**

Appendix B

Demographic Questionnaire

1. Please place an "x" in the appropriate box
   a. ☐ White
   b. ☐ African American
   c. ☐ Asian / Pacific Islander
   d. ☐ American Indian / Native American
   e. ☐ Hispanic
   f. ☐ Other

2. Age ☐ Years

3. Gender – place an "x" in the appropriate box

   ☐ Male ☐ Female

4. Have you ever been diagnosed with a mental illness? Place an "x" in the appropriate box

   ☐ Yes ☐ No

5. Has a member of your family ever been diagnosed with a mental illness? Place an "x" in the appropriate box

   ☐ Yes ☐ No

6. What is the geographical location of your current place of employment? Place an "x" in the appropriate box

   ☐ Urban ☐ Suburban ☐ Rural

7. What is the facility care level at your current place of employment? Place an "x" in the appropriate box

   ☐ Acute ☐ Intermediate ☐ Long-term

8. What is your present job title? Please fill in the box below
(Please do not specify job title if you are an administrator, write "administrator")

9. What is the number of years of experience you have in your current facility?

Years

10. How many years of experience do you have working in the forensic system?

Years

11. Please provide the number of trainings attended regarding recovery principles and services.

12. "What does recovery oriented care mean to you?" Please provide a narrative response in the space provided below.

Appendix C

Recruitment Outline

- March 2011: Mass mail out of recruitment letter (34 forensic hospitals)
    - Follow-up phone calls/e-mails 3-4 weeks following the recruitment letter
    - 3 hospitals responded and expressed interest
        - Hospital 1: contact made; direction to appropriate contacts; discussion of process for accessing hospital staff population for research (4 months). Contact made with state director of clinical research for forensic facilities and IRB documentation and directions given (3 months). IRB proposal and required state documentation composed for research with two forensic hospitals in the state (3 weeks). IRB approval (3months). IRB representative stated written approval for research was mailed to experimenter's home address but did not reach destination. Contact made with IRB representative to locate approval letter (additional 1 month). Clinical research director provided contact information for the administrators and psychology directors at the two state forensic facilities approved by the IRB.
            - E-mail and phone calls made to contacts. One hospital administrator responded and agreed to participate. Surveys and link for qualitative interview were provided. Five surveys were completed and mailed back. Qualitative interview on Survey Monkey was not provided despite the agreement to participate from the director. No response was obtained from the second hospital.
        - Hospital 2: Contact was established with the administrator and interest to participate was obtained. IRB approval to conduct research was not required. Surveys (20 as per the request of the administrator) and link to the qualitative interview were provided to the administrator. Experimenter received 5 survey responses and the qualitative interview was obtained. Additional recruitment efforts were made to obtain additional surveys from the twenty forensic staff members that did not respond. The administrator agreed to make an announcement in a staff meeting to remind individuals to participate if they were interested. No additional surveys were obtained. (4 months).
        - Hospital 3: Contact with the clinical research director was established and interest to participate in research was expressed. Director stated the legal department for the hospital needed to approve research project to move forward with the IRB proposal. Repeated efforts were made to obtain a response from the director regarding the outcome of

the legal inquiry. Correspondence and effort to re-establish contact occurred for 4 months. No response was obtained.

- March 2011: Referral from Dr. Kottsieper to recruit forensic hospital was provided. Correspondence occurred for approximately 1 month. IRB proposal outline was provided and IRB proposal was submitted (1 month).During the IRB review, the hospital's legal department required Informed Consent to be obtained from participants to approve the research project at the facility. Efforts were made to inform the facility that this study did not require Informed Consent as per the PCOM IRB due data collection being de-identified (3 months). The research study was not approved.
- October 2011: Referral from a psychologist in the BOP to a forensic hospital director. Repeated efforts were made to contact director. Correspondence via e-mail was established (2-months). IRB proposal documents were obtained. An ethics board stipulation to research at the facility required the experimenter to present research project to the board and be physically available for questions/problems during data collection. This facility was located out-of-state from the experimenter and availability at the facility was not possible.
- October 2011: 2nd Mass mail out of recruitment letter (30 forensic hospitals).
    - Follow-up 3-4 weeks following the recruitment letter
    - No responses obtained
- January 2012: Staff psychologists in the BOP contacted to inquire about contacts in forensic hospitals.
    - 2 forensic directors were contacted by staff psychologist to participate in research
    - No response obtained
- February 2012: Referral to the national state forensic administrator directory
    - Recruitment e-mail sent to 55 Directors
    - Follow-up e-mails and phone calls made 2-3 weeks following the initial e-mail
        - Forensic administrator agreed to participation in the qualitative interview and Survey Monkey link was provided.
            - No response obtained
        - Forensic administrator agreed to participate in the qualitative interview and Survey Monkey link was provided. The qualitative interview was obtained. The administrator also forwarded the request to seven other administrators.
            - One response obtained from forwarded request
        - 2 Forensic administrator forwarded the e-mail to the appropriate participant within the hospital
            - One response obtained
- March 2012: Psychologist referral to administrator in forensic hospital to complete the qualitative interview. Contact made and qualitative interview response obtained.

- June 2012: Psychologist contacted employed in state forensic hospital to acquire contact with the administrator to recruit for the qualitative interview.
- July 2012: 55 Directors re-sent letter of inquiry e-mail to recruit for only the qualitative portion of the study.
- Ten randomly selected directors called for recruitment for the qualitative portion of the study.

Appendix D

Outline of Themes

Outline of Themes	Number of Administrators that Endorsed Concepts
Category # 1: Implementation	
Concept: Holistic Treatment Programming	Ten Administrators
Concept: Consumer Driven Treatment	Eight Administrators
Concept: Staff Training and Education	Four Administrators
Concept: Hospital Mission and Values	Three Administrators
Concept: Community: Resources and Involvement	Four Administrators
Concept: Multidisciplinary Staff Approach	Three Administrators
Concept: Reduce Coercive Treatment	Two Administrators
Category # 2: Obstacles/Barriers	
Concept: Staff/Administrative Attitudes and Knowledge	Seven Administrators
Concept: Consumer Challenges	Two Administrators
Concept: Legal/Security Concerns	Five Administrators
Concept: Limited Resources	Six Administrators
Category # 3: Overcoming Obstacles	
Concept: Involvement and Communication	Seven Administrators
Concept: Public Relations	Three Administrators
Concept: Education and Training	Four Administrators
Concept: Focus on the Positive	Two Administrators
Concept: No Solution	Three Administrators
Category # 4: Facilitating Strategies	
Concept: Mission Statement and Values	Four Administrators
Concept: Staff Training and Supervision	Four Administrators
Concept: Consumer Involvement in Treatment and Policy	Six Administrators
Concept: Discharge Readiness	Four Administrators