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<td>Walsh, Francis Patrick; Meskell, Pauline; Burke, Emer; Dowling, Maura</td>
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ABSTRACT

This longitudinal study describes the effects of recovery based training on staff knowledge and attitudes to recovery. Mental health staff (n= 101) completed the study questionnaire (the Recovery Knowledge Inventory (RKI-20) and Recovery Attitudes Questionnaire (RAQ-16) before training and after six months. On the RKI, significant changes between pre and post training scores (p<0.01) were found. On the RAQ, scores showed significant changes in Factors 1 (p<0.001) and 2 (p<.009). The results indicate a significant difference in confidence using a recovery model of care following training suggesting that recovery based training positively effects staff knowledge and attitudes to recovery overall.

Key words: Recovery, training, mental health
INTRODUCTION

The purpose of this study was to determine the effects of a recovery based training in mental health on staff knowledge and attitudes to recovery. Recovery in mental health continues to gain increasing attention internationally (Frost et al., 2017; Pincus et al., 2017). However, approaches to recovery continue to have a biomedical focus, with pessimistic views on recovery more common (Morera, Pratt, D & Bucci, 2017).

Recovery in mental health services has many different meanings but centres around personal growth, hope and autonomy (Meehan, King, Beavis & Robinson, 2008). Recovery is based on a client’s perspective (Buckley-Walker, Crowe & Caputi, 2010) for whom recovery is seen as a continuing process of change which may or may not be illness focused (Anthony, 2000). This highlights the importance of making distinctions between personal and clinical recovery, the latter of which refers to a reduction or elimination of clinical symptoms as determined by measurements used by researchers and clinicians (Slade, 2009).

A lack of recovery knowledge and skills can hinder or impede implementation of a recovery approach. Health care professionals require support and education to develop recovery skills to promote an increase in knowledge which will improve outcomes for service users (Del Vecchio, 2015). Hence to move from a traditional care approach to a recovery approach it is important to focus and invest in health care professionals’ beliefs and attitudes to recovery (South London and Maldsley, 2010). This focus should also include supporting health care professionals to develop core recovery competencies (Clasen, Meyer, Brun, Mase & Cauley 2003), which include fostering hope, encouraging self-responsibility, collaborative
working, identifying strengths, promoting responsible risk-taking (Redko, Rapp, Elms, Snyder & Carlson 2007).

Recovery skills training for nurses can lead to better outcome measure for service users in the areas of taking control over their lives, finding meaning, feeling more empowered and managing their own mental health (Knutson, Newberry & Schaper 2013). Moreover, recovery training for staff can play a pivotal role in transition services from a traditional model to a recovery approach to services delivery (Bhanbhro et al., 2016).

Providing mental health practitioners and people with personal experience of mental health problems with a systematic education and training in recovery principles leads to positive changes in people’s knowledge, skills and attitudes towards recovery (Higgins et al., 2010). In Ireland, the Health Service Executive (HSE) launched the Advancing Recovery in Ireland project (ARI) in 2012. The aim of the project was and is to transform the culture and delivery of mental health services from a traditional model to recovery focused services. ARI now delivers a national standardised recovery principles and practice workshops/ training nationwide.

One element of the ARI project is the provision of training and education for all health care professionals. The focus of the programme is to begin a conversation on the recovery approach in mental health service delivery, with the aim of the training to give staff the opportunity to think and reflect on what the concept of recovery in mental health really means. Other aims of the programme include facilitating exploration of various definitions of recovery and to hear the voice of a person with lived experience and family members through
the recovery lens. The programme therefore promotes discussion on the principles of recovery and how these principles can be implemented into clinical practice.

ARI believes that a collaborative approach can lead to positive organisational cultural change outcomes. Co-produced and co-delivered recovery training modules can lead to better outcomes for health care professionals (Townend, Tew, Grant & Repper, 2008). ARI therefore involves training people in facilitation skills and these facilitators then deliver the recovery programme. The programme is guided by the principles of adult education and uses group work, individual work, and conversations. Each individual session is evaluated by participants and facilitators are paid.

ARI brings together a diverse group of participants involved in some way with mental health services. The group includes those who provide mental health services, those who use the service, and their families and community supports. Unique to this training is the co-produced and co-delivered aspect with training delivered by service users and family members. The workshop is guided by the principles of adult education and uses group work, individual work, conversations and reflective practice both at an individual and team perspective. The content of the workshop includes defining the concept of recovery, exploration of the recovery principles and how these recovery principles can be adopted into clinical practice. Each individual session is evaluated by participants and facilitators are paid.

The four hour training workshop was developed and facilitated by people who had ‘lived experience’ of mental health challenges, family members/carers of people with mental health challenges and service providers. During the reflective practice section of the training, the combined lived experience of service users, family members and service providers are
captured. Service users and family members share their own personal lived experience of recovery and speak about their experience of using services and offer their views on how services could be improved from a day to day quality of interaction perspective. This reflective component also allows mental health professionals to reflect on their attitudes to recovery and re-examine the basis for these attitudes and any identified barriers should be removed or reduced. A common barrier is a dominant focus on clinical recovery at the expense of personal recovery. Personal recovery acknowledges both clinical and personal recovery, and embraces a person’s view of a meaningful life determined by them, with or without symptoms.

THE STUDY

Purpose
The purpose of this study was to determine the effects of a recovery based training in mental health on staff knowledge and attitudes to recovery. The study was undertaken in two counties in the Western region of Ireland from 2015-2016 where a recovery based training programme was delivered for the first time. The research question was as follows:

Does a recovery based training programme have an effect on staff knowledge and attitudes to recovery?

Design
A longitudinal study design was used. Data was collected at two time points; just before training and six months after training.

Sample/study participants
The total population were mental health staff employed in two regional healthcare areas who participated in a mandatory training programme that focused on a recovery
oriented approach to mental health care. Details of the study were provided before the training and participants were advised that they would receive a hard copy questionnaire before the training programme and they would subsequently be asked to complete a similar questionnaire six months after the training (electronically). Participants were asked to provide details of their email addresses for the follow up questionnaire distribution which was administered via online survey software (www.surveymethods.com).

**Data Collection**

The training began in July 2015 and data collection commenced at this time. All participants were asked to complete the questionnaire at the beginning of the day and provide their email address on the questionnaire to allow follow-up. A total of 101 participants had undertaken the training and completed the questionnaire by March 2016. The 101 participants were contacted six months after their training with an invitation to complete the follow-up online questionnaire. Participants were given two weeks to complete the follow-up questionnaire. Reminders were sent after a week. The submission date for the majority of follow up questionnaires was extended by one week to facilitate completion as some participants contacted the research team requesting additional time due to clinical commitments. The final follow up questionnaires were dispatched in October 2016 with data collection concluding in November 2016.

**Study Questionnaire**

The study questionnaire focused on participants’ attitude to recovery and was based on a combination of two previously validated tools. It was divided into three sections, with statements in each section relating to the same issue, as grouping items meaningfully facilitates ease of completion (Cox, 1996).
The first section contained demographic questions around age, gender, job title, educational level, timing, structure and content of previous recovery training. This information was used to create a profile of the participants which allowed comparison between groups within the sample. Relevancy of demographic questions to the study objectives were ensured to avoid asking participants for unnecessary details (Sue and Ritter, 2007).

Section 2 was based on the Recovery Knowledge Inventory (RKI-20) (Bedregal, O'Connell & Davidson, 2006) which is a tool used to assess care providers’ knowledge and attitudes towards recovery orientated practices. It was originally developed in the US in response to an initiative to increase the recovery orientation of health services but has subsequently been used in many jurisdictions (Davidson, O’Connell, Tondora, Styron, Kangas, 2005). The RKI was originally a 36 item instrument which was then reduced to a 20 item scale. Items included in the RKI are rated on a 5 point Likert-style response format ranging from 1 (strongly disagree) to 5 (strongly agree). Responses to all items do not follow the same direction: some of the items if rated positively reflect a stronger recovery orientation, while the others if rated positively reflect less of a recovery-orientation. The RKI assesses four domains/factors of understanding regarding recovery as follows: Domain1, roles and responsibilities (7 items, reverse scored) mainly concerned with risk taking, decision making and roles and responsibilities of the different stakeholders in recovery. Domain 2, non-linearity of the recovery process (6 items, reverse scored) focusing on the role of illness and symptom management and the non-linear nature of recovery. Domain 3, the roles of self-definition and peers in recovery (5 items, positively scored), that focus on the person’s activities in defining an identity and a life that is outside of the label ‘patient’. Domain 4, expectations regarding recovery contains two items that are reverse scored.
Formulators of the RKI scale (Bedregal et al., 2006) report reliability analysis (Cronbach’s alpha) for the four domains as follows: 0.81, 0.70, 0.63 and 0.47 respectively. Factor 4 ‘Expectations regarding recovery’ was included even though it has a below acceptable reliability coefficient (Cronbach’s alpha 0.47), and a similar low reliability coefficient was obtained in this study for factor 4 (0.50). The alpha values obtained within this study were 0.93, 0.74, 0.56 and 0.50 and a coefficient of 0.84 for the total score.

Section 3 of the study questionnaire focused on attitudes to recovery and included a 16 item Recovery Attitudes Questionnaire (RAQ-16). The RAQ scale was developed in the US to compare attitudes to recovery from serious mental illness with different stakeholders groups such as patients, healthcare staff, family and the general public (Borkin et al., 2000). The RAQ was initially developed as a 21 item self-administered instrument. During the instrument validation process it was identified that respondent groups have different views of recovery, and that different items have varying levels of importance in each group. Following validation and psychometric property analysis the RAQ was refined into two instruments: a 16 item and a 7 item instrument, both measuring attitudes to recovery (Borkin et al., 2000). Within this study the RAQ-16 was chosen as the increased number of rateable items were considered to best reflect the different attitudes about recovery within four respondent groups: service users, family members, mental health professionals and the public (Ralph et al., 2000). The 7 item scale (RAQ-7) is more commonly used in the literature (Burgess, Pirkis, Coombs & Rosen, 2010).

On the RAQ, participants are asked to indicate their agreement with statements by using a Likert scale with the response format ranging from 1 (strongly disagree) to 5
(strongly agree). Recovery orientated outcomes such as empowerment, satisfaction with life, improved quality of life, increased opportunities and environmental impact are assessed. Higher scores indicate a more positive attitude about the idea of recovery. The alpha values (Cronbach’s alpha) in the original study was 0.65 for the total score (Borkin et al., 2000), the alpha values obtained within this study was 0.95. The RAQ-16 includes two domains/factors. Factor 1 consists of 4 items that relate to the suggestion that recovery is possible and needs faith. Factor 2 consists of three items that suggest recovery is difficult and differs among people.

The questionnaire design aimed to ensure that important aspects in relation to recovery oriented training were included. There are a number of other recovery instruments available, however it was important to manage the length of the questionnaire to reduce the time required for completion as completion time and response rate correlate (Edwards et al., 2002).

The questionnaire was reviewed by the research team, and a pre-test was carried out to test the questionnaire for any ambiguity in statements, overall clarity and clarity in relation to the instructions. A letter of invitation was sent to ten randomly selected mental healthcare staff who matched characteristics of the target population outlining the aims and objectives of the study. Potential pre-test participants were informed that the purpose of their participation was to evaluate and provide feedback on the instrument that was going to be used in the study. They were informed that they would not be part of the main study. Requested feedback included participant opinion of the length of the questionnaire, ease of understanding of instructions, items that were found difficult to complete or understand, and the overall organisation of the questionnaire. Six participants completed the pre-test (Response rate
(60%) and minor issues only were identified mainly around demographic questions, and revisions were made based on this feedback.

**Ethical Considerations**

Ethical approval to undertake the study was granted by the regional Health Service Executive (HSE) ethics committee.

**Data Analysis**

Data were analysed with IBM SPSS Statistics Version 22 (Statistical Package for the Social Sciences, IBM Corporation, 2014). Scales and subscales were examined by means and standard deviations (SD). The subscales and total scores were analysed to determine consistency using Cronbach’s alpha. RAQ-16 and RKI subscales and items were analysed using independent samples t test. One-way ANOVA was used to compare the domain mean scores and participant characteristics that contained more than two categories (time working in mental health care, current occupation). The relationship between RKI and RAQ total scales, subscales and demographic variables were analysed using independent-samples t tests by using pre-training and post training measures to determine whether there were any significant differences in scores.

**RESULTS**

A total of 101 participants completed the pre training questionnaire. The majority of participants were female (74%, n=71), with 26% male (n=25). There was a fairly even distribution of participants across age groups with less in the younger age group (<25, 6%) and the older age group (56-65, 11%). The majority of participants worked in the community (70.4%, n=69). While a variety of healthcare staff responded, nurses (18%, n=18), Clinical
Nurse Managers (14%, n=14) and Clinical Nurse Specialists (15%, n=15) were the largest groups represented. The majority of participants (92%) worked full time. The mean years working in mental health was 15.16. While 26% of participants had been working in mental health care 1-5 years, over 70% of participants had spent over six years working in mental health care and 40% had greater than 16 years’ experience working in mental health care (Table 1).

[Insert Table 1 here]

Less than half (49%, n=48) of the participants had previously undergone recovery training with 51% (n=50) indicating that they never completed any training on the recovery model of care and two participants (2%) did not answer the question. The most common type of training undertaken included short talks/lunchtime seminars (13.4%, n=13), one day training (11.3%, n=11) and half day workshops (10.3%, n=10). Two day training was relatively uncommon with a total of 3% of participants (n=3) having undertaken training in this way.

The participants who had indicated that they had undertaken training on recovery previously were asked to indicate when they had last undertaken training. The most frequent timeframe was 1-2 years ago with 18.6% (n=18) of participants indicating this, 14.4% (n=14) had training within the last year, 6.2% (n=6) between 3-5 years ago and 8.2% (n=8) more than 5 years ago. Training was most frequently provided by mental health staff (29.6%, n=29), with mental health staff, carers and service users delivering 9.2% (n=9) of training received, mental health service users delivered 2% (n=2) of training and 8.2% of participants
(n=8) indicated other types of training provision. Participants were asked to indicate whether they used a recovery model of care in their practice and the majority who answered (n=71) indicated that they did (91.5%, n=65).

Participants were asked to indicate their level of confidence in using the recovery model of care. The most frequently indicated level was moderately confident (43.2%, n=41), with 24.2% (n=23) indicating that they were very confident and 7.4% (n=7) were not at all confident. This compares with results post training which indicated that 47.2% (n=34) of participants were very confident, and 41.7% (n=30) were moderately confident (Figure 1).

An independent samples t test was conducted to compare means of the pre and post training data on confidence in using the recovery model of care. Results indicate there was a significant difference in confidence using a recovery model of care between pre training (M=3.06, SD = 0.94) and post training (M=1.83, SD = 0.98): t10.25 (309), p=0.001).

[Insert Figure 1 here]

**Recovery Knowledge Inventory**

Analysis of participants’ level of agreement with statements on the RKI demonstrated that there was change across agreement levels on all statements from pre training to post training with less participants choosing a ‘not sure’ option post training (Table 2). Percentage agreement levels with statements in all domains indicated that changes were evident in participants’ knowledge and attitude related to recovery potential. For ease of interpretation Likert choices ‘Strongly agree’ and ‘Agree’ were combined and ‘Disagree’ and ‘Strongly disagree’ were combined (Table 2). In Domain 1, responses reflected an increased belief that all people with mental illness need to be involved with making decisions about their care in order to effect recovery. Results indicated participants felt that sheltering the client from the
complexities of everyday life and possible disappointments it is not conducive to recovery. Over 80% of participants disagreed or strongly disagreed with all statements in Domain 1 post training which reflects a stronger recovery orientation post training (Table 2).

Domain 2 responses related to the non-linearity of the recovery process and indicated a lack of consensus on all statements with the highest ratings of ‘not sure’ post training of any of the domains: for example 21% of participants were ‘not sure’ if a person was more likely to recover if they complied with treatment. Participants were polarised on most statements, however 67% disagreed with the statement that suggested that there was little that a professional could do to help a person recover, if they were not ready to accept the illness and need for treatment (Table 2).

In Domain 3, responses post training reflected an increased belief that recovery is equally relevant in all phases of treatment and it can be positively impacted by both professional and non-professional interactions with the person with mental illness. Hobbies and leisure activities were important in recovery but there was a lack of consensus as to whether professionals should encourage service users to take risks in the pursuit of recovery (Table 2). Analysis of levels of agreement to statements in Domain 4 highlighted polarity with a broad range of agreement levels pre training. Post training agreements levels (66%) indicated an increased belief that everyone was capable of actively participating in the recovery process. Similarly, 64% did not agree that it was harmful to have too high expectations for service users (Table 2).

[Insert Table 2 here]
A comparison of RKI means and standard deviations between pre training and post training groups by domain are displayed in Table 3. Figure 2 illustrates the mean RKI scores pre and post training by domain. All domains showed significant changes between pre and post training scores (p<0.01). The highest mean scores post training were in Domain 3 which relates to roles of self-definition and peers in recovery (mean = 4.43, SD = 0.48). The lowest mean scores were for Domain 1 ‘roles and responsibilities (mean = 1.8, SD= .57) and Domain 4 expectations regarding recovery (mean = 2.38, SD = 0.90).

Pearson’s correlation indicated that there were no significant relationships between each domain score and years worked in mental health (correlation=-0.008, p=.947 for domain 1; correlation = -0.17, p=.887 for domain 2; correlation = -0.148, p=.215 for domain 3; correlation= -.0.64, p=.591 for domain 4). Moreover, independent t tests found no significant difference in mean scores by gender for Domain 1 (mean=2.01, SD=0.548) for males compared to (mean =1.785, SD= 0.577) for females; t= 1.525, df=70, CI-.07033 to .52748, p= 0.132); Domain 2 (mean= 2.90, SD=0.872) for males compared to (mean = 2.785’ SD= 0.855) for females; t=0.544, df=70, CI-.38245 to .57460, p= 0.588); Domain 3 (mean= 4.29, SD=0.3972) for males compared to (mean = 4.4885, SD= 0.430) for females; t= -1.787, df=70, CI-.41996 to .02304 p= 0.078); Domain 4 (mean= 2.60, SD=0.788) for males compared to (mean= 2.3077, SD= 0.929) for females; t= 1.243, df=70, CI-.17655 to .76116, p= 0.218).

Independent t tests found no significant difference in mean scores in comparing nursing and non-nursing professionals for Domain 1 (mean=1.870, SD=0.591) for nursing compared to (mean = 1.792, SD= 0.539) for non-nursing; t= 0.513, df=70, CI-.22524 to .38128, p= 0.609); Domain 2 (mean= 2.86, SD=0.895) for nursing compared to (mean=...
2.708, SD= 0.752) for non-nursing; t=0.680, df=70, CI=.29714 to .60482, p= 0.499); Domain 3 (mean= 4.45, SD=0.43084) for nursing compared to (mean= 4.370, SD= 0.426) for non-nursing; t=0.775, df=70, CI=.13784 to .31322 p= 0.441); Domain 4 (mean=2.4327, SD=0.934) for nursing compared to (mean= 2.2750, SD= 0.802) for non-nursing; t= 0.666, df=70, CI-.31482 to .63020, p= 0.508).

Independent t tests also found no significant difference in mean scores in comparing those working in long term care and those working in acute/community care for Domain 1 (mean=1.857, SD=0.267) for long term care compared to (mean= 1.848, SD= 0.592) for acute/community care; t= 0.32, df=70, CI-.52680 to .54386, p= 0.975); Domain 2 (mean=2.67, SD=0.697) for long term care compared to (mean=2.83, SD= 0.870) for acute/community care; t= -0.411, df=70, CI-.96046 to .63210, p= 0.682); Domain 3 (mean=4.72, SD=0.626) for long term care compared to (mean=4.411, SD=0.408) for acute/community care; t= 1.566, df=70, CI-.0842 to .70032 p= 0.122); Domain 4 (mean=2.40, SD=0.651) for long term care compared to (mean= 2.3881, SD= 0.916) for acute/community care; t= 0.29, df=70, CI-.82323 to .84711, p= 0.977).

[Insert Table 3 here]

Recovery Attitudes Questionnaire

Analysis of participants’ level of agreement with statements in the RAQ demonstrated that participants were relatively consistent in relation to their attitudes to recovery both pre and post training (Table 4). There were two statements where participants were polarised in their views or ‘not sure’ about the options. The first statement related to the concept ‘to recover requires faith’. A similar percentage of participants rated this as ‘not sure’ (32% pre
training, 33% post training). A slightly higher percentage agreed with the statement post training (47% pre training v’s 58% post training). The other statement on which participants were polarised was ‘recovery from mental illness can occur without help from mental health professionals’, with 19% ‘not sure’ pre training and 17% ‘not sure’ post training. A slightly higher percentage agreed with the statement post training (52% pre training v’s 68% post training). Results indicated that participants felt strongly that recovery was possible regardless of the cause (94%), and occurred even if symptoms persisted (100%). Results indicated that all participants (100%) acknowledged that setbacks were common in the recovery process and that people differed in the way they recovered (100%), with stigma seen as having a negative impact on the speed of the recovery (96%). People were helped in recovery if they understood their own mental illness and all participants (100%) felt that the family were significantly impacted from a loved one’s mental illness.

[Insert Table 4 here]

A comparison of RAQ means and standard deviations between pre training and post training groups by factor are displayed in Table 5. Both factors showed significant changes between pre and post training scores in Factor 1 (p<0.001) and in Factor 2 (p<.009). The highest mean scores post training was in Factor 1 ‘recovery is possible and needs faith’ (mean 17.22, SD1.87). The lowest mean scores were for Factor 2 which relates to the concept that recovery is difficult and differs among people (mean 13.54, SD 1.20). When analysed at the individual item level the means between pre and post training five statements showed a statistically significant change (Table 6) indicating a change in attitude in terms of a more positive attitude to recovery.
Independent t tests found a significant difference in mean scores by gender for Factor 1 (mean= -16.50, SD= 1.98) for males compared to (mean =17.5, SD= 1.77) for females; t= -2.070 df=70, CI-.1.96356 to -.03644, p= 0.042); There was no significant difference in mean scores by gender for Factor 2 (mean=13.300, SD=1.21) for males compared to (mean = 13.636, SD= 1.205) for females; t=-1.052, df=70, CI-.96888 to .29965 p= 0.296).

Independent t tests also found no significant difference in mean scores in comparing nursing and non-nursing professionals for Factor 1 (mean=16.00, SD= 2.16) for nursing compared to (mean= 17.294, SD= 1.85) for non-nursing; t= -1.37, df=70, CI-3.21037 to .62213, p= 0.182); Factor 2 (mean=13.250, SD=1.50) for nursing compared to (mean =13.558, SD= 1.20) for non-nursing; t= -.494, df=70, CI-1.5565 to .93900, p= 0.623). In addition, no significant difference in mean scores was found in comparing those working in long term care and those working in acute/community care for factor 1 (mean= 18.60, SD= 1.67) for long term care compared to (mean= 17.11, SD= 1.86) for acute/community care; t= 1.72, df=70, CI-.23234 to 3.1935, p= 0.089); Factor 2 (mean=14.00, SD= 1.22) for long term care compared to (mean =13.507, SD= 1.21) for acute/community care; t= -0.877, df=70, CI-.62767 to 1.6127, p= 0.384). Finally, Pearson’s correlation indicated that there was no significant relationship between RAQ Factors in score and years worked in mental health (correlation=-0.063, p=.600 for factor 1; correlation = -0.138 p=.247 for Factor 2).

[Insert Table 6 here]
The findings reported here add to a growing body of knowledge internationally supporting recovery training for mental health staff (Bhanbhro et al., 2016; Cusack, Killoury, & Nugent, 2016; Williams et al., 2016; Wilrycx, Croon, Van Den Broek, & Van Nieuwenhuizen, 2015). Our study reports on the effects of a recovery based training in mental health on staff knowledge and attitudes to recovery and addresses previous calls for more research on this topic (Cleary & Dowling, 2009; Gaffey, Evans & Walsh, 2016; Wilrycx et al., 2015). The knowledge and attitudes of Irish mental health care professionals to recovery has previously been reported (Clearly & Dowling, 2008; Gaffey et al., 2016). In the earlier study (Cleary & Dowling, 2008), recovery was viewed positively in terms of delivering mental health services and that more experienced staff had the least favourable attitude to recovery. In a replication study five years later of the aforementioned study, Gaffey et al. (2016) reported that the recovery knowledge among mental health care professionals had not improved and the knowledge gap had widened between nursing and allied mental health care professionals. Gaffey et al. (2016) also identified that no recovery training was offered to staff in that 5 year period.

The results reported here indicate that on the RKI, study participants demonstrated a change across agreement levels on all statements from pre training to post suggesting they were more knowledgeable and felt more equipped to rate statements post training. The highest change in scores on the RKI was found for Domain 3 (related to roles of self-definition and peers in recovery). This suggests that participants believed that service users can pursue recovery irrespective of the stage of treatment they are in, whether that be in acute inpatient or outpatient settings. Moreover, it suggests that participants believe that in order to promote recovery, they must support positive risk taking, and pursuit of a daily routine
with hobbies. Support for service users to find personal meaning and re-establish roles and identity is also suggested in this high score for Domain 3.

Meehan and Glover (2009) reports similar findings in their study where the RKI was used in a non-equivalent control group study and participants were also assessed for changes 6 months post recovery training. Wilrycx et al., (2015) also report the indirect positive effects of a Dutch recovery-oriented training program for mental health professionals. Using the Mental Health Recovery Measure (MHRM), they report positive results for service users on two subscales of the MHRM, ‘Self-empowerment’ and ‘Learning & new potentials’. Self-empowerment was also viewed important by respondents in our study. Responses overall to the RKI reflected an increased belief that all people with mental illness need to be involved with making decisions about their care in order to effect recovery. However, there was a lack of consensus as to whether professionals should encourage service users to take risks in the pursuit of recovery. There has traditionally been a long association between mental illness and risk. Mental health care providers are required to manage the risk of those who use the services while also promoting the right to freedom, agency and choice. Taking risks is a fundamental part of human experience that supports personal growth and recovery. Positive therapeutic risk taking enables service users to make decisions about their safety and to pursue personal recovery goals. However, professionals can experience tension striving from a balance between the interests of the service user, society and the organisation (Felton, Wright & Stacey, 2017).

The lowest scores were for Domain 1 ‘roles and responsibilities’. This result may be explained by the diverse participant group and the service user groups they are working with. Service users with severe and enduring mental health issues will have more challenges and
may not take an active part in their own recovery and managing their own mental health. It is less challenging to work with service users who are engaged in managing their mental health and recovery. Also scoring low was Domain 4 ‘expectations regarding recovery’. If staff’s expectations for a service user’s recovery are not met this can have a negative impact on the individual’s recovery. The setback should be used as an opportunity to reflect and plan how to approach things different. However, often staff can respond by trying to ‘manage’ the person’s expectations to protect them from failure which goes against the philosophy of the recovery process.

In our study, significant changes were evident on the RAQ scores between pre training and post training groups in two factors, ‘recovery is possible and needs faith’ and ‘recovery is difficult and differs among people’. In terms of ‘recovery is possible and needs faith’, mental health professionals believe that recovery for service users is more attainable if service users have a belief and faith that they can recover (Larson, Sawyers & McCullough, 1997). Faith means a religious belief that they can regain control over their lives and manage their mental health while living a meaningful life determined by themselves with or without the symptoms of mental illness. In relation to ‘recovery is difficult and differs among people’, the recovery journey is unique to each individual, can be challenging for many, and with ups and downs. Recovery is a process and not an end point exhibiting problems, challenges and setbacks and learning from those experiences.

To conclude, international evidence clearly indicates the importance and benefits of recovery training for staff. There is also some evidence to suggest that the type of recovery training may have an influence on staff attitude to recovery. A recent US based study (Tsai, Salyers & Lobb, 2010) concludes that training that is ‘general/inspirational’ in focus may not
have the same ‘staying power’ as ‘specific/practical training’. This study adds to this evidence and in particular illustrates how a co-produced and co-delivered recovery training programme for mental health staff can change knowledge and attitudes to recovery. However, it is also important to highlight that the organisational culture also plays a role in determining if recovery training changes practice and pre-training sessions with staff to identify any potential barriers may be useful (Gee, Bhanbhro, Cook & Killaspy, 2017).

**Limitations**

This study has a number of limitations. Prior to the training, the majority of the professional mental health staff had undertaken recovery modules as part of their undergraduate education. This may have influenced baseline scores at the time of the training and subsequently reduced significant changes to scores at follow-up. The groups attending the training were a mix of professionals and non-professionals; if these groups had attended separately, the findings may have been different. The follow-up time period of six months may be too soon to determine if the changes are lasting. Finally, if staff attending the training had returned to a non-recovery focused service, any lasting effects of the training may not be possible.

**CONCLUSIONS**

This longitudinal study provides evidence to support the role of recovery based training in changing staff knowledge and attitudes to recovery. While all domains on the RKI showed significant changes between pre and post training, the highest change in scores found for Domain 3 (related to roles of self-definition and peers in recovery). On the RAQ, the highest changes in scores were shown in Factor 1 ‘recovery is possible and needs faith’. These results indicate a significant difference in confidence using a recovery model of care.
between pre and post training and suggest that recovery based training positively effects staff knowledge and attitudes to recovery. However, because the organisational culture plays a role in determining if recovery training changes practice, pre-training sessions with staff to identify any potential barriers should be considered by those embarking on delivering recovery training for staff.

A recovery approach in practice involves working intensively and for prolonged time periods with clients and this requires investment in resources (Gilburt, Slade, Bird, Oduola & Craig, 2013). The first investment must be recovery training for staff, an approach to transforming the recovery vision into practice (Le Boutillier, Leamy, Bird, Davidson, Williams & Slade, 2011). Training can provide an important mechanism for instigating change through promoting recovery-orientated practice which in turn can result in cultural change towards a recovery approach within the organisation (Gilburt et al., 2013). Training also influences the knowledge and attitudes of staff towards recovery and this can positively affect the quality of experience for service users and family members attending mental health services (Shepherd, Boardman & Slade, 2008). Staff have identified the qualities they see as essential to the implementation of recovery in practice, including experience, caring, flexibility, commitment, energy, open-mindedness, a positive attitude and open to change (Gilburt et al., 2013). Recovery training can go some way in raising awareness of, and cultivating these qualities, which inherently drive an individual’s desire to practice a recovery oriented approach.

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