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ABSTRACT

Recovery is the model of care presently advocated for mental health services internationally. The aim of this study was to examine the knowledge and attitudes of mental health professionals to the concept of recovery in mental health. A descriptive survey approach was adopted and 153 health care professionals (nurses, doctors, social workers, occupational therapists and psychologists), completed an adapted version of the Recovery Knowledge Inventory (RKI). The respondents indicated their positive approach to the adoption of recovery as an approach to care in the delivery of mental health services. However, respondents were less comfortable in encouraging healthy risk taking with service users. This finding is important because therapeutic risk taking and hope are essential aspects in the creation of a care environment that promotes recovery. Respondents were also less familiar with the non-linearity of the recovery process and placed greater emphasis on symptom management and compliance with treatment. Multidisciplinary mental health care teams need to examine their attitudes and approach to a recovery model of care. The challenge for the present and into the future is to strive to equip professionals with the necessary skills in the form of information and training.

Key words: Acute care, community care, multidisciplinary care, recovery, scales and assessment

Introduction

Recovery is difficult to define, since there is no succinct or universally accepted definition. Within the literature the term recovery has been interchangeably used to mean "a model, philosophy, approach, a paradigm, a movement or vision"(Roberts & Wolfson 2006, p.20). The notion of recovery in the present-day mental health field is inconsistently understood and used. However, it continues to gain popularity despite lack of consensus.

Embracing a recovery model challenges professionals to expand and grow in different ways (Clement 1997). The joint position paper of the Social Care Institute for Excellence (SCIE) (2007) stresses that for staff to provide effective recovery orientated services they first need to attend to their own hope and morale, as both concepts are contagious with implications for service users.

Embracing recovery necessitates a shift in values, attitudes, and a shift in power. Recovery challenges professionals to develop practice changes such as being less formal in professional roles. Professionals need to be able to manage their own personal anxiety when service users take risks and respect their expertise by experience (Schrank & Slade 2007). This re-conceptualisation of role will include an understanding that the professional role "will become facilitative rather than directive in nature, hope inspiring rather than pessimistic, and autonomy enhancing rather than paternalistic" (Sowers 2005, p.770). However it must be noted that there is a paucity of well controlled research studies supporting a recovery based approach to care (Mental Health Commission 2005,

Oades *et al.* 2005). Much of the evidence to date is narrative, and there is a need to gather and strengthen the evidence base in order to validate this approach (Roberts & Wolfson 2004).

Recovery research, often in the form of a qualitative narrative rather than empirical studies, describes recovery as a non- linear journey affected by a complex array of factors. The literature suggests that recovery needs to be viewed as an integrated part of peoples' everyday lives, and as least as much a social as a personal and unique process. Common themes for service delivery that reflect the ideologies exposed by the recovery movement are focused on the significance of hope and optimism, valuing the expertise of the service user, valuing diversity, and allowing for risk taking behaviors. A change in attitude and a deeper understanding of the concept of recovery is required for mental health professionals to adopt this philosophy of care. Therefore the knowledge and attitudes of mental health professionals in both acute and community settings were explored and outlined in this study.

The aims and objectives of the research

The purpose of this study was to examine the knowledge and attitudes of mental health professionals to the concept of recovery in mental health.

METHODS

Study participants and procedure

The target population was five disciplines of mental health professionals working on community mental health teams and acute admissions facilities in a service provision area in one Irish Health Service Executive (HSE) area (Table 1).

Table 1 Professional grade of respondents.

Professional Grade	**No.**	**%**
Staff Nurse (S/N)	52	40
Nurse Manager	19	15
Clinical Nurse Specialist (CNS)	16	12
Senior House Officer (SHO)	11	8
Psychiatrist	5	4
Senior Registrar	4	3
Psychologist (Senior)	3	2
Psychologist(Basic Grade)	2	2
Social Worker (Senior)	4	2
Social Worker (Basic Grade)	2	2
Occupational Therapy Manager	2	1
Occupational Therapist (Senior)	2	2
Occupational Therapist (Basic Grade)	2	2
Profession/grade not specified	6	5

264 nurses and 53 other mental health professionals were used as the sampling frame for the study. Time limits on the study meant that all nurses in the sampling frame could not be sent the study questionnaire. Therefore, nurses (n=100) were randomly selected from the sample frame (n=264). All members of the smaller disciplines were included in the study (n=53) (these were grouped together to increase sample size to permit statistical analysis and valid comparisons). One hundred and fifty three (45% of sampling frame) were then sent an adapted version of the RKI (Bendregal *et al*. 2006).

Data Collection Instrument

The RKI (Recovery Knowledge Inventory) consists of 20 statements on a five point likert scale, and assesses four different domains of understanding on recovery in mental health.

Reliability analysis (Cronbach's alpha) reported by Bedregal *et al.* (2006) are as follows: 'Roles and responsibilities in recovery'(- .81), 'Non-linearity of the recovery process' (- .70); 'The role of self-determination and peers in recovery'(.63), and Expectations regarding recovery (- .47). Despite the low score for component four, this domain was included due to the importance of the item in assessing staff expectations regarding recovery and people in recovery (Bendregal *et al.* 2006).

Permission was given to use the RKI (Recovery Knowledge Inventory) in an Irish setting and to make minor adaptations; this being the exclusion of the term "substance abuse", but no changes was made to the wording of the questions.

The questionnaire also included five demographic questions and three closed questions asking for respondents' exposure to recovery information and training. Moreover, two open questions were included to seek views regarding the skills professionals require to promote recovery, and to offer an opportunity for further comments on the topic. The questionnaire underwent pre-testing with a mix of disciplines working in both community and acute facilities before the study was undertaken.

Ethical issues

The study proposal was reviewed by the local research ethics committee and approval obtained.

Data Analysis

Parametric statistics were utilised in the analysis of the data and Burnard's (1991) content analysis framework was adapted to examine and code the qualitative data.

Results

One hundred and thirty questionnaires were returned (n=130) (response rate of 85%). The primary socio-demographic characteristics of the study participants are outlined in Table 2.

Table 2 Profile of respondents

	No	**%**
Gender		
Male	45	35
Female	85	65
Work setting		
Acute Unit (Admission wards in psychiatric in-patient facilities)	33	26
Community (Community mental health teams)	79	61
Acute/Community (Work in both of the above)	16	12
Work setting not indicated	2	1
Profession		
Medical	21	16
Psychology	5	4
Nursing	92	71
Social Work	6	5
Occupational Therapists	5	4

Years worked in Mental Health		
1-10 years	44	35
11-20 years	30	23
21-30 years	42	32
31-40 years	11	8
Non- response	3	2

RKI scores for components /themes in recovery

Comparing the overall mean scores between the four components on the RKI (Table 3), respondents obtained the highest mean/standard deviation score of 4.03 (.65) on component three, "The role of self definition and peers in recovery". This indicates that mental health professionals appreciate the need for the person in recovery to have an identity outside their diagnosis, and also acknowledges the key role peers play in the recovery process. The next highest mean score of 3.79 (.68) was on component one, "Roles and responsibilities in recovery" indicating that respondents showed good understanding of the responsibilities of both the client and the professional in the treatment and rehabilitation process. The third highest mean score of 3.08 (1.01) was on component four "Expectations regarding recovery." While respondents reported that recovery was relevant to all phases of treatment, there was a large unsure response as to how realistic expectations could be employed. Respondents lowest mean score 2.80 (.69) rested on component two "The non-linearity of the recovery process". This result indicates that respondents were least familiar with the nature of the recovery process.

Table 3: Overall mean scores for all of the recovery components.

Recovery components	N	Minimum	Maximum	Mean	Standard Deviation
Roles and responsibilities in recovery.	126	2	5	3.79	.688
Non-linearity of the recovery process.	127	1	5	2.80	.694
The role of self-definition and peers in recovery.	127	2	5	4.03	.654
Expectations regarding recovery.	128	1	5	3.08	1.016

Statistical significant findings

Parametric tests in the form of the independent t Test were used to test for any statistically significant differences between the groups. The groups were divided into two categories, nursing and non nursing (all small disciplines were grouped together). The non-nursing disciplines were grouped together for statistical purposes but also because this group's history and tradition may not struggle with empowerment issues like nursing. In light of empowerment being central to recovery, it was thought that making this comparison between the two groups might possibly produce interesting findings.

The t test was utilised at 5% (0.05) level of significance. The confidence level was set at 95% (CI 95). Levene's test (2-tailed) for equality of variances was utilised to compare the following:

- Knowledge and attitudes of respondents working in acute facilities versus community settings
- Nursing discipline attitudes and knowledge to the concept of recovery compared to non nursing disciplines (Table 4)
- If length of experience working in mental health influenced attitudes and knowledge towards recovery (Table 4). (A cut off point of 15 years' experience

was chosen because in the initial frequencies, 47% of respondents had worked 15 years or less and 51% had worked greater than 15%, with 2% not answering the question)

- Attitudes of male respondents versus female respondents (Table 4)

There was no significant statistical difference found between knowledge and attitudes of respondents working in acute facilities as distinct from community settings. These findings may be influenced by the fact that all disciplines with the exception of nurses work across both settings. However, it was noted that community respondents had higher mean scores for three of the four components of recovery. Nevertheless, while not statistically significant this finding may be of clinical significance. La Fort (1993) suggests an actual difference in mean performances scores, as in this instance, is a strategy for determining the clinical significance of research findings.

Table 4: Significant statistical findings of independent t tests

	Recovery Competencies	**t**	**df**	**P**	**Mean**
Level of Experience **<15 years** **>15 years**	Non-linearity of the recovery process.	2.202	120	.030	2.83 2.57
Gender Differences	Role of self-definition and peers in recovery	-2.667	125	.009	3.87 (Male) 4.13 (Female)
	Expectations regarding recovery	-2.268	126	.025	2.66 (Male) 3.06 (Female)
Nursing V **Non Nursing**	Roles and responsibilities in recovery	2.717	123	.008	3.68 (Nursing) 4.00 (Non-Nursing)
	Non-linearity of recovery process	4.437	124	.000	2.86 (Nursing) 3.02 (Non-Nursing)

(P<0.05)

Significant statistical differences were found in relation to the "non-linearity of the recovery process" between respondents with <15 years and respondents >15 years experience in mental health (Table 4). Less experienced staff had more favorable attitudes and knowledge than more experienced respondents. T = 2.202, df = 120, P=0.03, (P<0.05). Less experienced respondents had a higher mean score (2.83) for this component than experienced respondents (2.57). There was no significant statistical difference found for any of the other three components of recovery with regard to experience.

There was a significant statistical difference found regarding the "role of self definition and peers in recovery" between female and male respondents, t= -2.667, df = 125, P= .009 (P<0.05) (Table 4). Females attained a higher mean score (4.13) than males (3.87). Furthermore, a significant statistical difference was found between female and male respondents regarding "expectations regarding recovery" t=-2.268, df =126, P =.025, (p<0.05); females attaining a higher mean score (3.06) than males (2.66). While there was no statistical difference between the genders for the remaining two components, females had the highest mean scores. This would suggest that females had more favorable attitudes and knowledge about recovery than males.

There was a significant statistical difference found between non-nursing and nursing grades regarding "roles and responsibilities in recovery" (Table 4). Independent *t* Test t=2.71, df =123, P=.008, (P<0.05). Non-nursing grades attained the highest mean score (4.00), when compared with a mean of (3.68) for nurses. Similarly, with the "non-linearity of the recovery process" there was a significant statistical difference found

between disciplines, t= 4.43, df =124, P=.000, ($p<0.05$), with a mean of (3.05) for non nursing grades and (2.52) for nurses. Non-nursing grades also scored higher means on both other recovery components.

Findings from additional questions on information needs and training in recovery

Three questions asked respondents about their information needs regarding the concept of recovery, and if they had received recovery training (Table 5).

Table 5: Questions regarding information needs and training in recovery

Question	Yes	No
Read recovery information	81 % (n=105)	18% (n=23)
Received recovery training	22% (n=29)	75 % (n=98)

Question	More	Less	About the same
Information needs	88% (n=114)	2% (n=3)	10% (n=13)

Content analysis of the comments and suggestions offered qualitatively in response to the open-ended questions revealed a recurring theme of the need for more information, education, and training and specialist skills in recovery. The majority of respondents had no formal training in recovery principles, and those with exposure to the concept gained their knowledge through informal methods rather than structured programmes.

Furthermore, responses to the questions on the key skills required by mental health professionals in helping clients in their recovery fell into the following three themes: counselling skills, collaborative working and sharing knowledge. In addition, many respondents stressed the importance of good communication/interpersonal skills.

Respondents also offered comments on the importance to be able to work collaboratively with clients in a holistic fashion, and empowering clients. One respondent identified, *"putting clients needs first before their own".* While another identified *"working with clients as opposed to directing them towards institutional goals".* Another respondent eloquently depicted recovery skills as follows: "*Tolerance, patience, listening to client's own goals, accepts change disappointment and failure. Be open and honest, source all help available; be prepared for the long haul, hasten slowly".*

The importance of collaborative working with fellow team members was also identified and an awareness of each discipline's role was identified, as was the sharing of information. This is revealed in the following comment: *"The experience and wisdom to know which resource on a team is appropriate at different times of the recovery process."* Another respondent called for *"team working as a skill, not just on paper…"* Finally, knowledge was a recurring theme in the responses offered. Respondents identified having knowledge and education on clients' illness, and the ability to share and explain this knowledge with the client as important. The importance of being able to *"recognise symptoms, explain the illness and show possible options for recovery"* was proffered by one respondent to illustrate this view. Such responses emphasize the importance of using a biological, psychological and social approach to management of illness in keeping with a recovery approach to care.

Discussion

The study findings suggest that recovery is viewed positively as a philosophy of care for delivering mental health services, and an overwhelming majority of respondents requested further training and education in the recovery model. However, the fact that the study was conducted at a time when a recovery philosophy is being advocated as the way forward in Irish mental health services must be noted when analyzing the findings, as participants may well have been influenced to respond in a positive manner.

It was also found that respondents have less knowledge and discerning attitudes to the themes of "non-linearity of the recovery process", "risk taking", and "hope." Similar findings are reported by Bedregal *et al.* (2006) who found that mental health professionals were least familiar with the process of non-linearity, and the role of hope in recovery. The study also revealed that less experienced staff and non-nursing grades had more favorable attitudes and knowledge to this component.

The shift from an illness focus to a recovery focus which embraces the notion of the non-linearity of the process is facilitated by professionals having realistic expectations for service users, and having the ability to instill hope. Respondents in this study scored poorly on this component with one in three (34%) unsure how to develop realistic expectations for service users to participate in their recovery, and almost a further one third (30%) disagreed with having expectations. Where professionals have low expectation for service users, they delay the recovery journey and in fact encourage learned helplessness (Roberts & Wolfson 2004).

Respondents undervalued hope, which is a critical finding, as hope and optimism are considered the first principle underpinning a recovery approach offering the possibility of recovery from mental Illness (Mental Health Commission, 2008). The corollary implication is that in the absence of hope, recovery is less likely to occur. However, respondents also expressed a need for more training to assist with developing realistic expectation for service users' own hope. This finding is encouraging because professionals who cannot foster hope cannot assist in the recovery process (Repper & Perkins 2003).

The study findings also indicate that respondents were uncomfortable encouraging therapeutic risk. However, risk taking is the core of community care (Harrison 1997). Nevertheless, risk is commonly regarded as something negative and to be avoided and frequently defined in terms of physical harm to self and others (Ryan 2001). The management of risk therefore, needs a comprehensive multidisciplinary approach to care with good communication and information sharing and clear lines of responsibilities ad accountability (Wright & Stockford 2001). However, there is a dearth of literature promoting therapeutic risk taking otherwise referred to as positive risk taking (Stickley & Felton 2006). Another difficulty is the tensions that exist between policies and practice. On one hand is the promotion of choice and freedom, and on the other, the endorsement of control is evident (Barker 2000). Therefore, professionals are placed in the difficult position between two competing forces of positive risk taking and risk management.

Shared decision-making in mental health encourages open communication, in an honest genuine manner (Hawks 1992, Rodwell 1996) based on mutual trust, respect participation

and a commitment to education (Malby 1992). Importantly, these factors were identified in this study by respondents as key skills required by professionals to help clients in their recovery. However, respondents also repeatedly requested support and education to enable them to embrace this new way of working.

Respondents in this study were acutely aware of the necessary skills required to facilitate empowerment and promote recovery. Qualitatively, they identified collaborative partnership approaches utilising core counselling skills and sharing knowledge through education as the vehicle to recovery. The importance of the interpersonal relationship between professional and service user is well documented in the literature (Smith 2000). Central to this relationship is the need for an equal relationship between professional and service user (Pieranunzi 1997), where reciprocity is embraced (Dorrer & Schinkel 2008).

Respondents in this study also acknowledged the need for information, training and education for both professionals and service users in order to embrace working within a recovery ethos. They also raised the issue of the importance of interprofessional learning as a team and the need for a multidisciplinary team approach to care.

Study limitations

The study was undertaken across one service provision area; therefore, the findings are not representative of the population as a whole. Furthermore, a bigger sample would have allowed a statistical comparison of individual disciplines. However, the study has further endorsed the use of the Recovery Knowledge Inventory (RKI) as a valid tool for assessing staff training needs regarding recovery.

Implications and conclusion

The study findings are encouraging overall, with respondents having good knowledge and favorable attitudes to the role of self definition in recovery and the importance of peer support in the process. Notwithstanding that the concept of recovery was not homogeneously appreciated, it was nevertheless warmly embraced by respondents. Indeed the yearning for more training and information signaled respondents' interest in recovery.

The challenge for existing MDT professionals elicited from this study is to examine their attitudes and approach to care. Hope and optimism ought to be present, as should the aim of promoting social inclusion and opportunities. Services that are recovery focused typify a philosophical approach to service delivery that compliments other interventions that may be provided to ameliorate the symptoms of mental illness (Sowers 2005). Implementing such recovery orientated services will undoubtedly require extensive commitment from services and professionals at all levels embracing a willingness to change and be innovative about practice. Recovery cannot be an "add on" to existing services, supports or systems (Davidson *et al*. 2007, p. 31), and professionals must "start and end with a message of hope" (Townsend & Glasser 2003, p. 85).

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