

**THE DEVELOPMENT OF RECOVERY COMPETENCIES FOR  
IN-PATIENT MENTAL HEALTH PROVIDERS WORKING WITH  
PEOPLE WITH SERIOUS MENTAL ILLNESS**

by

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## Abstract

**Objectives.** The transformation of the mental health system toward a recovery-orientation has created a growing demand for training and education to equip providers with recovery competencies. The purpose of this thesis is to develop a recovery competency framework addressing the most salient components of recovery competencies required for providers practicing in in-patient contexts and to construct and test an education program accordingly.

**Methods.** This thesis involved three phases. Phase One used competency development strategies to develop a recovery competency framework. Data collection methods included a literature review and 15 key informant interviews. In Phase Two, based on the recovery competency framework, a recovery education program was constructed and validated. In Phase Three, a pilot study with a pre-test/post-test design was used to examine the effectiveness of the education program. Twenty-six in-patient providers from three hospitals were recruited. Outcome measures included the Recovery Knowledge Inventory, two investigator-developed questionnaires rating participants' sense of recovery knowledge application and perceived recovery-related dilemmas, and a group evaluation.

**Results.** Two conceptual models were developed in Phase One to address key tensions and enabling processes for in-patient providers. Derived from these two models, a recovery competency framework consisting of eight core competencies was developed. Phase Two was comprised of a two-part education program. Part One was a self-learning program introducing recovery concepts in the in-patient context and the recovery competency framework. Part Two was a group learning program focusing on real-life dilemmas relevant to the in-patient context and applying the Appreciative Inquiry approach to address these dilemmas. In Phase Three, providers who participated in the education program showed improvement in recovery knowledge and sense of recovery knowledge application after the self-learning program. Participant evaluations of the group learning program were positive. The results indicated that in-patient providers may benefit from this education program.

**Conclusions.** This thesis addressed tensions related to recovery and highlighted the important role providers play in promoting recovery through the development and validation of the context-specific competency framework and education program. The broad dissemination of the study results will be an important step in promoting recovery in in-patient settings.

## Co-Authorship

A manuscript adapted from Chapter 3 has been published online in *Administration and Policy in Mental Health and Mental Health Services Research* and can be cited as:

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# Chapter 1

## Introduction

### 1.1 General Introduction

Following the deinstitutionalization of people with serious mental illness (SMI) in the 1960s and 1970s and the coming to prominence of community services and community integration in the 1980s, recovery became a new paradigm in the mental health field in the 1990s (Anthony, 1993). Recovery as a guiding paradigm counters long-held perspectives that have assumed that people with serious mental illness have a poor prognosis, will experience chronic illness, will function at a low level and pose a danger to the community (Grausgruber, Meise, Katschnig, Schony, & Fleischhacker, 2007; ÜÇOK, 2007). The concept of recovery emphasizes that a person can live a satisfying, hopeful, and productive life no matter what limitations have been caused by the mental illness (The Standing Senate Committee On Social Affairs Science and Technology, 2006, p. 5). Drawing upon opinions from a wide range of stakeholders, the American Substance Abuse and Mental Health Services Administration published a national consensus statement that comprehensively defined mental health recovery as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (Substance Abuse and Mental Health Services Administration (SAMHSA), 2006).

As growing research evidence supports the conclusion that recovery is achievable for people with serious mental illness, many countries have integrated a recovery vision into their mental health policies, including Canada, the United States, England, New Zealand, and Australia (Piat & Sabetti, 2009). In Canada, the Standing Senate Committee on Social Affairs, Science and Technology declared that “recovery must be at the centre of mental health reform” in their report on transforming mental health,

mental illness, and addiction services (The Standing Senate Committee On Social Affairs Science and Technology, 2006, p. 5). The Mental Health Commission of Canada also declared “people of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being” as the first goal of the framework for a mental health strategy for Canada (Mental Health Commission of Canada, 2009). The Ontario Provincial Forum of Mental Health Implementation Task Forces has promoted recovery-based mental health reform since 2002 (Final Report of the Provincial Forum of Mental Health Implementation Task Forces Chairs, 2002). Even preceding the work of the Provincial Forum, some recovery principles were embedded in Ontario’s mental health policy, *Making It Happen* (1999).

In the United States, publicly-funded mental health services have moved from a primary focus on treatment to the development of a comprehensive recovery-oriented system (Substance Abuse and Mental Health Services Administration (SAMHSA), 2006). As well, the recovery orientation has been adopted in New Zealand’s Mental Health Commission Blueprint for Mental Health Services and Australia’s National Mental Health Plan 2003-2008 (O’Hagan, 2001; Australian Health Ministers, 2003). In the United Kingdom and Ireland, official mental health documentation puts emphasis on recovery as the guiding principle of mental health service provision (England Department of Health, 2003; England Department of Health, 2005; Mental Health Commission Ireland, 2006; Mental Health Commission Ireland, 2008). Thus, the perspective of recovery has become a worldwide foundation for mental health policy and service systems.

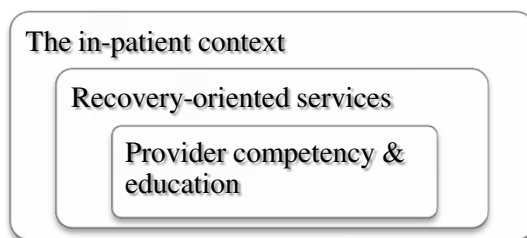
Recovery is a multi-faceted construct and involves all aspects of a person’s life. It does not mean that a person is cured. Recovery involves a process of developing new meaning and purpose in life in the context of living with a psychiatric disability (Anthony, 1993). Such a definition implies that a person increases control over his or her life and changes his or her attitudes, values, feelings, goals, skills, and/or

roles. In contrast to a treatment-oriented approach that primarily targets symptom reduction, the process of recovery includes improving methods of coping with symptoms and of handling secondary consequences of the mental illness (Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005). Recovery is viewed as a developmental and a non-linear process, in which people may re-experience acute distress and intense forms of service support such as in-patient hospitalization. In this way, hospitalization is seen as a part of the recovery process, where a person might have the opportunity to make some progress, take time to integrate what he or she has learned, and move forward in the recovery journey. However, while recovery has increasingly become a focus of mental health practice, the emphasis has been mainly on adopting recovery within community-based mental health services. The extent to which the recovery vision has been implemented in in-patient settings has not been widely promoted and researched.

Mental health service providers' understanding, beliefs, values, and attitudes about recovery are one of the key elements in the mental health system transformation towards a recovery orientation. Related literature suggests that many mental health providers still hold negative views about the potential for people with SMI to move beyond the limits of mental illness (Chinman, Kloud, O'Connell, & Davidson, 2002; Rickwood, 2004). McVanel, Younger, Doyle, and Kirkpatrick (2006) indicated that a significant barrier to recovery was providers' resistance to change and negative attitudes towards recovery. With the recognition that service providers may not have attitudes, knowledge or skills, attention has been focused on identifying the provider competencies required for effectively delivering recovery-oriented services. For example, the New Zealand Mental Health Commission developed a set of recovery-based competencies as a training standard to educate providers in the context of the New Zealand mental health system (New Zealand Mental Health Commission, 2001). Schinkel and Dorre (2006) also developed a recovery competencies framework for mental health workers in Scotland. These

efforts are intended to address the importance of workforce education in a recovery-oriented mental health system. Education is presented as a significant way to ensure provider competencies.

This thesis focuses on identifying recovery competencies required for in-patient mental health providers and developing an education program for the improvement of provider competencies in delivering recovery-oriented services in the in-patient context. The scope of the thesis encompasses three levels: 1) system level: the in-patient context; 2) program level: the recovery-oriented practice model; and 3) individual level: provider competency and provider education (see Figure 1-1).



**Figure 1-1 The scope of the thesis**

## **1.2 Problem Statement**

The major problem addressed in this thesis is that mental health providers are not equipped with adequate competencies to provide recovery-oriented services in the in-patient context.

Inconsistent with a recovery perspective, the current in-patient context is often described as adopting a traditional medical and illness-focused orientation and applying a custodial framework with limited considerations of individual needs (Glasby & Lester, 2005; Mullen, 2009). The prevailing values, beliefs, and decision-making processes of the traditional medical model are not compatible with recovery. For example, practicing from a medical model, service providers may view themselves as traditional care providers and teachers rather than supporters and partners in recovery (Pejlert, Asplund, Gilje, &

Norberg, 1998). During the transformation of the mental health system to one that privileges a recovery orientation, Ashcraft and Anthony (2008) found several sequential levels of provider resistance to recovery. The first level involves providers thinking people are much sicker than the general population and seeing themselves as already operating according to a recovery model. The second level involves providers claiming that they do not have enough time, funds, and organizational support to carry out the recovery approach; moreover, they dispute that recovery is an evidence-based practice. The third level of provider resistance is a hopeless feeling about the recovery approach. The fourth level involves providers' resistance to sharing power with peer workers and changing current practice. Finally, the last line of resistance is related to psychiatrists who do not agree with recovery-oriented practice. These forms of resistance can be found in different mental health practice settings including the in-patient context. However, Ashcraft and Anthony found that providers who initially resist changes often later become those who strongly advocate for changes. Ashcraft and Anthony then suggested some strategies for addressing these resistances, for example, by providing training, real participation in recovery plans, and accessing peers (Ashcraft & Anthony, 2008).

In Salyer, Tsai, and Stultz's study (2007), hospital-based providers demonstrated significantly fewer recovery-positive attitudes because the population they served tended to be more severely ill or in greater need. As Jorm, Korten, Jacomb, Christensen, and Henderson (1999) found, in general, providers' attitudes may be negatively biased by greater contact with persons with persistent or recurrent disorders. Hospital-based providers have fewer opportunities to work with individuals with SMI who have been successful in the community, a limitation that also contributes to this bias. Providers' enthusiasm is thus thwarted when working with persons with serious mental illness. Johansson, Skärsäter, and Danielson also indicated that an unacceptable imbalance in power between clients and staff existed in the in-patient psychiatric ward, in which staff tried to take complete control of clients. Providers working in in-patient



wards showed lower levels of recovery orientation than those working in other practice settings.

Therefore, applying recovery-oriented practice may be more challenging in the hospital-based context than other practice settings, especially for in-patient providers (Johansson, Skärsäter, & Danielson, 2006).

Numerous recovery-competency documents have been reported (e.g. Coursey, et al., 2000; New Zealand Mental Health Commission, 2001; Schinkel & Dorre, 2006; Young, Forquer, Tran, Starzynski, & Shatkin, 2000), but none addresses the competencies specifically for providers working in the in-patient setting. While recovery competencies have been identified, educational programs to develop these competencies have rarely been developed. In addition, the design and validation of in-service training curricula that emphasize recovery competencies rather than disciplinary traditions has been limited. Only six studies have investigated the effectiveness of recovery-focused training (Axiom Market Research and Consultancy, 2006; Crowe, Deane, Oades, Gaputi, & Morland, 2006; Meehan & Glover, 2009; Peebles, et al., 2009; Salgado, Deane, Crowe, & Oades, 2010; Young, et al., 2005) and, most of the research sites that evaluated recovery training programs were in the community. The development of an effective way to change attitudes and increase competencies among in-patient service providers is imperative to working within a recovery-orientated system.

## **1.3 Purpose Statement, Research Questions, and Overall Research Design**

### **1.3.1 Definition of key terms**

In this thesis, *in-patient settings* include acute and long-term units in tertiary care hospitals specializing in the treatment of mental illness in Ontario, Canada. *In-patient providers* are defined as mental health professionals who currently provide clinical services for people with serious mental illness in adult in-patient units and include managers, nurses, occupational therapists, psychiatrists, psychologists, recreation therapists, and social workers. *Serious mental illness* can be defined using the

three dimensions of diagnoses, disability, and duration (Ontario Ministry of Health and Long-Term Care, 1999, p. 11). People with serious mental illness are diagnosed with schizophrenia, mood disorders, paranoid, or other mental disorders where psychosis is prevalent. They experience severe disruption in major life activities and social relationships of daily life. The duration of symptoms and functional impairments is longstanding, persisting over months or years. *Recovery competency* is defined as attitudes, knowledge, skills, and behaviours a provider needs in order to effectively deliver recovery-oriented services to people with serious mental illness.

### 1.3.2 Purpose statement, research questions, and overall research design

This thesis is comprised of a series of studies involving three phases. Table 1-1 illustrates the study design across the three phases. The overall purpose of the thesis is to develop and test a recovery education program for in-patient mental health providers to increase their recovery competencies. The thesis seeks to answer the overall research question: Can a focused, context specific educational program improve the recovery competencies of in-patient mental health providers?

**Table 1-1 The study design across three research phases**

Phases		Purposes	Research methods
Phase One:	Recovery competency framework development	Identifying the most salient components of recovery competencies and the learning needs of the in-patient providers	Competency development strategies including a literature review and key informant interviews
	↓		
Phase Two:	Education program development	Constructing the recovery education program for in-patient mental health providers	Program development involving 3 steps: a) determination of educational strategies; b) determination of content and format; c) production
	↓		
Phase Three:	Education program evaluation	Examining the effectiveness of the education program	A pilot study with a simple pre-test/post-test design

The overall research design is based on the Knowledge to Action (KTA) model which illustrates the process of Knowledge Translation at the Canadian Institutes of Health Research (Graham, et al., 2006; Tetroe, 2007). The KTA process is divided into two phases, knowledge creation phase and the action phase. The knowledge creation phase emphasizes the synthesis of knowledge using quantitative or qualitative methods and the creation of knowledge tools to present knowledge in a clear format and to meet stakeholders' needs. The action phase presents an activity cycle leading to implementation of knowledge. There are seven steps involved in this cycle: 1) identifying problem; 2) adapting knowledge to local context; 3) assessing barriers to knowledge use; 4) tailoring and implementing interventions; 5) monitoring knowledge use; 6) evaluating outcomes; and 7) sustaining knowledge use. This process of knowledge translation from the research findings to real-world applications was applied in the research design in this study from Phase One – examining providers' needs and identifying the competencies, to Phase Two and Three – developing and testing the education program to translate the knowledge.

Phase One of the thesis used competency development strategies to assess in-patient providers' educational needs and identify the most salient components of recovery competencies. This phase aimed to assess the in-patient context in relation to recovery and develop a competency framework. Data collection methods included a literature review and key informant interviews with stakeholders. The research questions addressed in the first phase included “What are the most salient components of recovery competencies required for providers working in in-patient programs in psychiatric hospitals?” and “What do providers need to change from the current practice to recovery-oriented services?” This qualitative investigation served as a needs assessment for tailoring workforce education to prepare providers for recovery-oriented practice. The final product in this phase was a recovery competency framework for the in-patient hospital-based context. This phase is related to the knowledge creation phase and the first problem identification step of the action phase in the KTA model.

Based on the recovery competency framework developed in Phase One, a recovery education program was constructed and validated in Phase Two. The development of the education program involved three steps: determination of educational strategies, determination of the content and format, and the final layout. The end product for the second phase was an education program that is effective in improving hospital-based mental health providers' recovery competencies. This phase is related to the second to fourth steps of the action phase (tailoring implementation in the local context and assessing barriers) in the KTA model.

To examine the effectiveness of the education program, a simple pre-test/post-test pilot study was conducted in Phase Three. Hypothetically, the implementation of the educational program would improve in-patient providers' recovery competencies. The research question in the third phase was "Will the providers who participate in the educational program show improved competencies in delivering recovery-oriented services?" This phase involved monitoring the implementation and evaluating the outcomes - the fifth and sixth steps of the action phase in the KTA model.

#### **1.4 Overview of the thesis**

This is a manuscript style thesis consisting of 6 chapters. Chapter 1, Overall Introduction, provides background information for the thesis and an overview of the overall research design. Chapter 2, Overall Literature Review, reviews current recovery literature as a groundwork for the thesis. Chapter 3, Competency Development, describes Phase One of the study targeting the development of the recovery competency framework for in-patient mental health providers. Chapter 4, Program Development, is Phase Two of the study, illustrating the process of the education program development. The education program is included at the end of Chapter 4 as a final product of this chapter. Chapter 5, Program Evaluation, describes Phase Three of the study, which examined the effectiveness of the education program. Finally,

Chapter 6, Overall Discussion and Conclusion, integrates the three phases of the study and discusses the research processes and outcomes as well as further implications for the field.

## Chapter 2

### Literature Review

The intent of the literature review is to unpack the notion of recovery from the large body of recovery literature. Studies in the review were identified through a combination of search strategies including literature searches on MEDLINE, PsycINFO, EMBASE, Health and Psychosocial Instruments, and CINAHL, and inspection of previous reviews. Databases were searched using combinations of the following terms: *recovery*, *recovery model*, *mental health*, *serious mental illness*, and *system transformation*. Recovery literature specifically associated with addiction and intervention with children and the elderly was excluded, as the focus of the thesis was adults with serious mental illnesses. Only articles published from 2000 onwards were included in order to better understand the current status of the recovery orientation in the mental health field. Specific literature related to each phase of the study, for instance, the implementation of recovery concepts in the in-patient context, recovery competency frameworks, and recovery education programs, is reviewed in the relevant chapters that follow.

Drawing upon the literature, recovery has been conceptualized from various perspectives and appears to have multiple layers of meaning. Providers from different professions, for example, nursing, occupational therapy, and social work, have made contributions to the growing body of knowledge about recovery and have incorporated recovery as a guiding principle in their practice or have critically reflected on how their professional practice can be informed by recovery (Carpenter, 2002; Kelly, Lamont, & Brunero, 2010; Lal, 2010; Repper, 2000). Within the literature, the terms “recovery from” versus “recovery in” have somewhat different connotations. “Recovery from” serious mental illness means an individual’s experience of remission of symptoms and a return to a previous state of health. On the other hand, “recovery in” serious mental illness involves an individual’s use of his/her strengths in

managing the illness and reclaiming a meaningful life while continuing to have a mental illness (Davidson & Roe, 2007). Some people describe recovery as an ongoing process, whereas other people refer to recovery as an outcome. Recovery has been viewed as a concept, a philosophy, a belief, a value, a vision, a paradigm, a framework, an approach, or a practice model, depending on the context. Scholars have identified a need to clarify the concept of recovery (Meehan, King, Beavis, & Robinson, 2008), to develop a shared meaning, if it is to be useful as a guiding vision. This broad review of the recovery literature intends to understand recovery from its various perspectives and definitions, various conceptual models and practice models, and issues raised at the system level. The review is organized by four sub-sections: 1) section one elaborates the divergent definitions of recovery from medical, rehabilitation, and consumer perspectives; 2) section two reviews conceptual recovery models that represent related recovery concepts in conceptual frameworks; 3) section three reviews practical recovery models which are tools for understanding and linking theories to everyday practice; and 4) section four looks at the recovery literature from the system level and reviews issues emerging in the context of system transformation toward a recovery orientation.

## **2.1 Divergent perspectives of recovery**

Contemporary conceptualizations of recovery have been influenced by the perspectives held by various stakeholders in the mental health system. From the clinical or medical perspective, recovery has been defined as the amelioration of symptoms and the restoration of function sufficient to resume personal and social activities (Davidson & Roe, 2007). “Symptoms” and “functioning” are two major concerns of recovery. Consistent with this clinical view of recovery, Liberman and colleagues in 2002 proposed an operational definition of recovery using four dimensions: symptomatology, vocational functioning, independent living, and social relationships. Achieving recovery, by this definition, requires

the duration of two consecutive years of the following: 1) sustained remission of psychotic symptoms; 2) full- or part-time involvement in work or school; 3) independent living without supervision; and 4) participating in active friendship, social events, or recreational activities (Lieberman, Kopelowicz, Ventura, & Gutkind, 2002). Accordingly, the medical perspective tends to view recovery as an outcome which denotes people's relief from mental symptoms and evidence of performance in social roles.

From the perspective of psychiatric rehabilitation, recovery is viewed as a developmental process. When people first experience a serious mental illness, they can feel overwhelmed or stuck and denial is a common phenomenon. Recovery is viewed as the process of recognizing the problem, reconstructing a new life, developing a new definition of the self, and improving quality of life. "Transformation" is the central idea here. Through the recovery process, people grow, change their views, and find new meaning in their lives (Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005; Jacobson, 2001; Spaniol, Wewiorski, Gangne, & Anthony, 2002).

From the perspective of consumers, or individuals who experience serious mental illness, recovery appears to have two major meanings (Piat, Sabetti, & Couture, 2009). In the first definition, recovery is linked to the illness experience, for example, a cure, the right medication, and a return to former self. Deegan (2001), a well known consumer and recovery scholar, defines this perspective as the "restitution narrative" which refers to a person's wish to return to the former self (Deegan, 2001). The second definition views recovery in relation to "wellness". Such a perspective implies that consumers actively engage in their own recovery process, take charge of their lives, and ultimately transform the self. It is a process of discovering how the limits of mental illness open up new possibilities. In the recovery process, a person changes, learns, grows, and integrates in order to develop a new self. Ridgway conducted a qualitative study in 2001 that examined first person accounts of recovery from psychiatric disability. Consumers identified recovery as a complex and nonlinear journey that involves reawakening



of hope after despair, achieving understanding and acceptance, moving from withdrawal to engagement, active coping rather than passive adjustment, reclaiming a positive sense of self, moving from alienation to a sense of meaning and purpose, and receiving support and partnership (Ridgway, 2001). From this perspective, recovery is a deeply personal journey and a transformative experience. People with serious mental illness want to seek an explanation for their experience, to control the disability, and to establish themselves in meaningful and productive roles (Spaniol, Wewiorski, Gangne, & Anthony, 2002). As Davidson and Roe suggested, consumers may have different meanings of recovery at different stages of their recovery process (Davidson & Roe, 2007).

The aforementioned three perspectives of recovery show some divergence. First, the medical perspective defines recovery as a static outcome which means no symptoms and a return to premorbid status. However, the rehabilitation and consumer perspectives view recovery as a life-long developmental process aimed at integrating into community and finding a new meaning of life. A person can recover even if having some symptoms. Recovery is an attitude and a way of life rather than a return to health or other clinical outcomes. Second, in terms of interventions, the medical perspective uses objective measurements to determine people's status. Medication and training are two major tools for achieving recovery. On the other hand, subjective narrative and supportive environment are keys to recovery from the consumer perspective. In this case, the rehabilitation perspective seems to be more comprehensive by including both subjective and objective evaluation and both skill development and environmental accommodation. The third issue is medication. From the medical perspective, the continuation of medication is necessary, while some consumers tend to have the opposite opinion - that medication is not necessarily needed. For this long-debated issue, the rehabilitation perspective proposes that medication can be seen as a tool to manage the illness. As people gain control of themselves, they know the best way to use medication.

The rehabilitation and consumer perspectives of recovery guide the vision of this thesis as they share a more similar ideology. In conclusion, recovery involves the entire self including the physical, psychological, emotional, and spiritual aspects and the interaction of the self with the environment. There is a need to find common ground among these various perspectives as they are not mutually exclusive. Although recovery can be conceptualized from different perspectives, working in a recovery-oriented fashion requires that providers allow consumers to define recovery according to their own views; at the same time, providers must be able to take into account all these various meanings.

## **2.2 Conceptual models of recovery**

Recovery is a complex construct that encompasses several underpinning sub-concepts which can be referred to as components or elements. The fundamental components of recovery identified within the large body of literature are individualized, person-centered, strengths-based, and non-linear, with a focus on hope, acceptance, positive sense of self, and empowerment (Davidson & White, 2007; Jacobson, 2001; Jensen & Wadkins, 2007; Mead & Copeland, 2000; Merryman & Riegel, 2007; Torgalsbøen, 2005; Shepherd, Boardman, & Slade, 2008; Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005). A person in recovery will gradually develop increased control, self-management and illness-management skills, personal responsibility, capacity to change, improved quality of life, productivity, meaningful engagement, and support networks (Davidson, Borg, Marin, Topor, Mezzina, & Sells, 2005; Davidson & White, 2007; Jacobson, 2001; Jensen & Wadkins, 2007; Mead & Copeland, 2000; Merryman & Riegel, 2007; Spaniol, Wewiorski, Gangne, & Anthony, 2002). Moreover, this person will move towards overcoming social stigma and endeavor to self-advocate. Self-responsibility is a central recovery component whereby people move away from being passive recipients to being empowered to actively engage in the decision making processes that impact their lives (Bonney & Stickley, 2008). There are

several examples in the literature of conceptual models developed to clarify and map the sub-concepts of recovery. The following models are empirically-based or widely-cited examples.

In 2005, Ochocka, Nelson, and Janzen interviewed twenty-eight individuals with serious mental illness and used a grounded theory analysis to construct a conceptual recovery framework. Four main components of recovery were identified: a drive to move forward, a spiral of positive and negative changes, the context of recovery, and a dialectical process of ongoing negotiation between self and external circumstances. This framework viewed recovery as a multidimensional process involving a person's initial intrinsic motivation to move forward, and followed by an ongoing negotiation between the self and the external circumstances. Finally, as a result of a successful negotiation, the person experiences an increased drive to continue moving forward (Ochocka, Nelson, & Janzen, 2005)

In 2008, Lloyd, Waghorn, and Williams constructed a four domain model of recovery from a literature review. The four domains of recovery identified are: 1) clinical recovery, which aims to achieve meaningful treatment goals and to obtain optimal treatment and care; 2) personal recovery, which aims to establish a meaningful life and a positive sense of self; 3) social recovery, which transfers social skills and maximizes social inclusion in the community; and 4) functional recovery, which is a recovery of the ability to fulfill a person's respective life roles. This model captures components of recovery from the views of service users, providers, family members, and the wider community. It is important to address all aspects of recovery in order to provide a comprehensive and effective intervention (Lloyd, Waghorn, & Williams, 2008).

In 2009, Davidson et al. developed "A Model of Being in Recovery" based on a combination of the first-person accounts and a series of qualitative studies conducted over the period of 15 years and across 4 countries. This model identifies 9 components of being in recovery: 1) renewing hope and commitment to one's life; 2) being supported by others; 3) finding one's niche in the community; 4)

redefining self; 5) incorporating illness; 6) managing symptoms; 7) assuming control; 8) overcoming stigma; and 9) becoming an empowered citizen. These 9 components describe the recovery process beginning with an individual's everyday efforts to live with the illness, as well as addressing the recovery plan at the level of practice and systems as a whole. This model also informs the ways to develop instruments for measuring recovery-oriented practice (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009).

In 2009, Slade proposed the "Personal Recovery Framework", which organized factors associated with recovery and identified four crucial recovery tasks a person needs to accomplish during the recovery process (Slade, 2009). These four tasks are developing a positive identity, framing the mental illness, self-managing the mental illness, and developing valued social roles. Drawing on the synthesis of these tasks, providers can use four approaches to support recovery: fostering identity-enhancing relationships, promoting well-being, framing and managing the mental illness, and improving social inclusion.

These four conceptual models integrate recovery concepts from the angles of recovery processes, categories, and tasks (see Table 2-1). They provide a foundation for clarifying various concepts of recovery.

**Table 2-1 Summary of the reviewed recovery conceptual models**

Authors	Domains/tasks/processes of recovery	Concepts
Ochocka, Nelson, & Janzen, 2005	1) a drive to move forward 2) a spiral of positive and negative changes 3) the context of recovery 4) a dialectical process of ongoing negotiation between self and external circumstances	Recovery as a process
Lloyd, Waghorn, & Williams, 2008	1) clinical recovery 2) personal recovery 3) social recovery 4) functional recovery	Recovery as categories
Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009	1) renewing hope and commitment to one's life 2) being supported by others 3) finding one's niche in the community 4) redefining self 5) incorporating illness 6) managing symptoms 7) assuming control 8) overcoming stigma 9) becoming an empowered citizen	Recovery as a process
Slade, 2009 Personal Recovery Framework	1) developing a positive identity 2) framing the mental illness 3) self-managing the mental illness 4) developing valued social roles	Recovery as tasks

### 2.3 Recovery practice models

The development of practice models or programs is an important means of helping providers translate recovery concepts and ideas into clinical practice. The following section reviews five recovery practice models: the Wellness Recovery Action Plan (WRAP) Program, The Tidal Model of Mental Health Recovery and Reclamation, Illness Management and Recovery, the Collaborative Recovery Model (CRM), and The Recovery Workbook - Practical Coping and Empowerment Strategies for People with Psychiatric Disabilities. Research evidence was reviewed to assess the effectiveness of these programs.

The Wellness Recovery Action Plan (WRAP) Program, developed by Copeland in 1989, is one of the most widely applied recovery practice programs (Davidson, 2005). WRAP is a self-management program for people with mental illnesses, which focuses on exploring resources for people's recovery and helping them manage their illnesses. Consumers can use WRAP as a tool, with the assistance of recovery facilitators, to set personal goals and to make action plans. There are six steps involved in the WRAP program: 1) Developing a Wellness Toolbox, 2) Daily Maintenance Plan, 3) Triggers, 4) Early Warning Signs, 5) Things are Breaking Down and Getting Worse, and 6) Crisis Planning. Each step involves exercises, making plans, and practices. The action plan must be developed by the person who will use it. Anyone, including family members, peers, and health care professionals, can be WRAP facilitators. There are training programs available for facilitators in order to effectively assist consumers in using WRAP (Copeland, 2001; Copeland, 2011). Evidence from the most recent literature indicates that participation in WRAP has improved consumers' psychiatric symptoms, sense of hope, and quality of life (Cook, et al., 2011; Fukui, et al., 2011), as well as improved both providers' and consumers' attitudes and knowledge about recovery (Doughty, Tse, Duncan, & McIntyre, 2008). Scott and Wilson in their article support the potential of WRAP to lead a new era of mental health intervention but suggest that WRAP should be applied with some adaptations, such as understanding its limitations and not implementing the program with "the one-size-fits-all enthusiasm" (Scott & Wilson, 2011).

The Tidal Model of Mental Health Recovery and Reclamation is a well-known recovery approach initially developed by the nursing professionals, Barker, Buchanan-Barker, and their colleagues. It is now practiced by various disciplines across the mental health field. The Tidal model conveys the meaning of people's experience through water metaphors and focuses on the continuously changing process of human experiences, the critical role of narrative, and the importance of working in partnership. "Self", "world", and "others" are three dimensions of care incorporated into the Tidal process of recovery. A set of values

called “the Ten Commitments” allows the model to guide providers with a philosophical focus. The Ten Commitments are valuing of voice, respecting the language, developing genuine curiosity, becoming the apprentice, using the available toolkits, crafting the step beyond, giving the gift of time, revealing personal wisdom, knowing that change is constant, and being transparent. Twenty Tidal competencies are identified under the Ten Commitments to assist with recovery practice by generating practice-based evidence for the model. Tidal model programs have been developed and put into practice in the UK, Ireland, Canada, Japan, Australia, New Zealand, and the USA across the mental health practice spectrum from acute care to community services (Buchanan-Barker & Barker, 2008; Barker & Buchanan-Barker, 2010; Barker, 2001). For example, The Royal Ottawa Mental Health Centre has reported the broad implementation of the Tidal Model in their nursing practice since 2002 (Brookes, Murata, & Tansey, 2008).

There is research evidence supporting the effectiveness of the Tidal model. Quantitative studies demonstrated the model’s effectiveness in increasing consumer participation in care and resultant decreases of the following: lengths of stay, violence and self-harm behaviours, the use of restraints, and the interval between admission and assessment (Stevenson, Barker, & Fletcher, 2002; Gordon, Morton, & Brooks, 2005; Lafferty & Davidson, 2006). Although the reduction of such incidents during in-patient admission demonstrates the recovery outcomes through the lens of “clinical effectiveness,” it cannot directly imply a positive recovery process. The question of how to measure the recovery process remains. The use of consumer language and the level of consumer participation, two important components of the Tidal model, still need to be evaluated. Qualitative analysis also demonstrated that, among patients and nurses, the application of the Tidal model resulted in a more hopeful attitude, a sense of collaboration and power sharing, and an enhancement of sense of self (Cook, Phillips, & Sadler, 2005; Lafferty & Davidson, 2006).

Illness Management and Recovery is a group of specific interventions that help consumers working with providers in managing their mental illness, improving self-efficacy, and gaining mastery over their lives in order to pursue their recovery goals. Five major interventions with evidence from randomized clinical trials were reviewed by Mueser and colleagues. These five interventions are broad-based psychoeducation programs, medication-focused programs, relapse prevention, coping skills training and comprehensive programs, and cognitive-behavioral treatment of psychotic symptoms (Mueser, et al., 2002). Increasing knowledge of mental illness, reducing relapses and rehospitalizations, reducing the severity of symptoms, making progress toward personal goals, and improving general functioning, self-efficacy, and quality of life were positive outcomes related to participation in the Illness Management and Recovery Programs (Mueser, et al., 2002; Hasson-Ohayon, Roe, & Kravetz, 2007; Fujita, Kato, Kuno, Suzuki, & Uchiyama, 2010). Consistent with the focus of this thesis, Bartholomew and Kensler (2010) demonstrated a project implementing the Illness Management and Recovery Program in US state psychiatric hospitals. The authors described the step-by-step project planning as well as strategies for successful implementation of the program. Those strategies included administration support, volunteer group facilitators, stakeholder participation, patient self-selection, focused training, modeling the practice, cross-discipline clinical supervision, appropriate group facilitation, and supporting patient goals through homework and skill acquisition (Bartholomew & Kensler, 2010). Whitley et al. also demonstrated the application of the approach in community mental health settings and analyzed the facilitators and barriers of implementation, concluding that strong leadership, an innovative organizational culture, effective training, and committed staff were key factors of success (Whitley, Gingerich, Lutz, & Mueser, 2009).

In Australia, the Collaborative Recovery Model (CRM) is presented as a practice model that integrates evidence-based practices in the mental health field to assist providers in supporting the recovery process (Oades, Deane, Crowe, Lambert, Kavanagh, & Lloyd, 2005). The CRM consists of two



guiding principles, “recovery as an individual process” and “collaboration and autonomy support,” and four components, “change enhancement”, “collaborative needs identification”, “collaborative goal striving”, and “collaborative task striving and monitoring,” totaling six training modules with four specific protocols for implementation. The four protocols are motivational enhancement, needs assessment, collaborative goal technology, and homework assignment. Providers require specific training (the collaborative recovery training program) to acquire the competencies to implement the CRM model. The effectiveness of the CRM has been examined by Australian researchers. One study, for instance, indicated that consumers working with CRM-trained providers identified significant changes in taking responsibility, building collaborative relationships with staff, and achieving personal goals through homework activities (Marshall, Oades, & Crowe, 2009).

“The Recovery Workbook: Practical Coping and Empowerment Strategies for People with Psychiatric Disabilities” has been developed by the Center for Psychiatric Rehabilitation at Boston University (Spaniol, Koehler, & Hutchinson, 1994). This program can be utilized as an individual self-help guide or in consumer-led group settings. The specific goals of the workbook are to help people become aware of the recovery process, increase knowledge and control, become aware of the importance and nature of stress, enhance personal meaning, build personal support, and develop goals and plans of action. The workbook includes the following chapters: introducing recovery, increasing knowledge and control, managing life stress, enhancing personal meaning, building personal support, and setting personal goals. Each chapter consists of worksheets and exercises to guide users working through the program to achieve their goals. Barbic, Krupa, and Armstrong conducted a randomized controlled trial to evaluate the effectiveness of the program. The results indicated that the Recovery Workbook group program was effective in increasing the perceived sense of hope, empowerment, and recovery among community dwelling individuals with serious mental illness (Barbic, Krupa, & Armstrong, 2009).

These five models are examples of evidence-based practical recovery models. They translate the recovery theory to clinical practice through a task-oriented design supporting provider daily usage. They demonstrate ways to address the gap between recovery as a philosophy and as an empirically validated service delivery model.

## **2.4 Recovery-oriented mental health system**

Over the last two decades, recovery has been well studied at the individual level, and has focused on factors related to a person's recovery from serious mental illness. At the same time, a movement among individuals receiving services has voiced its concerns about the need to change the mental health system from the traditional medical model to one guided by a recovery-oriented vision. This movement stimulated a process of reflection and appraisal at the system level and led to the transformation of mental health policies worldwide.

The recovery movement has originated, in part, from the civil rights movements of the 1960s and 1970s. From the consumers' and families' perspectives, the barriers to recovery are identified more as social and political issues rather than emerging from the mental illness itself. This perspective leads to the concept of recovery focusing on people's rights to a safe, dignified, and personally meaningful life (Davidson, Tondora, Lawless, O'Conne, & Rowe, 2009). Contemporary recovery policy has integrated the philosophical ideal of human rights. Another movement influencing policy transformation has been the paradigm shift in mental health practice from a traditional biological or medical model toward a recovery orientation. A response to this paradigm shift has been the re-evaluation of expected outcomes of treatment and service delivery for mental illness (Noordsy, Torrey, Mead, Brunette, Potenza, & Copeland, 2000). The new treatment goals and outcomes place the central emphasis on person-centred

features such as autonomy and self-agency and moved the person beyond disability. Accordingly, mental health system transformation has become a focus of the emerging literature about recovery (Anthony, 2000; Davidson, Tendora, & O'Connell, 2007; Farkas, Gagne, Anthony, & Chamberlin, 2005; Jacobson & Curtis, 2000; Sowers, 2005; Mulvale & Bartram, 2009).

A recovery-oriented mental health system includes programs and services that adopt recovery concepts as their guiding principles (Farkas, Gagne, Anthony, & Chamberlin, 2005). Recovery-oriented programs identify and build upon people's strengths to support them in managing their conditions while regaining meaningful participation in their own lives (Davidson, Tendora, & O'Connell, 2007). The focus of transformed mental health systems and services is on the individual first, and includes a person's right to make decisions and choices, to experience full partnership in all aspects of his or her recovery, and to explore the resources in the community. According to these principles, a recovery-oriented mental health program is characterized by program structures such as its mission, policies, procedures, record-keeping, workforce training, and quality assurance that are consistent with fundamental recovery values (Farkas, Gagne, Anthony, & Chamberlin, 2005).

In 2005, Sowers proposed a recovery-oriented program design that included three domains: administration, treatment, and supports. In the administration domain, key issues included organizational commitment to recovery, intensive staff training to ensure adequate understanding of recovery concepts, and consumers' involvement in continuous quality improvement and outcome assessment to empower them and to foster the establishment of a recovery environment. The second domain, treatment, highlighted a variety of program options to enable consumers to choose a collaborative relationship between consumers and providers, and to ensure consumers' access to all their treatment records. The third domain, support, focused on the facilitation of contact with and participation in consumer advocacy and mutual support groups, family education and empowerment programs, and basic support programs

such as transportation or housing (Sowers, 2005). Some recovery instruments have been designed to assess the recovery-orientation of services and practices at the system level, for example, the AACP ROSE- Recovery Oriented Service Evaluation developed by the American Association of Community Psychiatrists, the Recovery Enhancing Environment Measure (REEM) developed by Ridgway, the Recovery Oriented Systems Indicators Measure (ROSI) developed by Dumont, Ridgway, Onken, Dornan, and Ralph, and the Recovery self-assessment (RSA) developed by O'Connell, Tondora, Croog, Evans, and Davidson (Ralph, Kidder, & Phillips, 2000; Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005). These instruments are designed for organizations to monitor their organizational climate and progress toward developing recovery-oriented services. The use of such instruments can help organizations enhance services and inform program improvement (Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005). The two volumes of the compendium of recovery measures developed by Ralph et al. in 2000 and Campbell-Orde et al. in 2005 were appended in the recovery education program in Chapter 4 (Ralph, Kidder, & Phillips, 2000; Campbell-Orde, Chamberlin, Carpenter, & Leff, 2005).

Mulvale and Bartram (2009) demonstrated the processes of transforming the mental health system in a Canadian context. Developing the strategies for the system transformation occurred in two phases. Starting in 2008, the first phase called the "WHAT" phase focused on determining visions and goals by building support through consultations with stakeholders. In the first phase, the document of the Mental Health Commission of Canada (MHCC) proposed a comprehensive approach to mental health system transformation and placed a recovery orientation at the centre of reforms for people with mental illness. The second phase was the "HOW" phase of strategy development, which involved research and consultations to determine the ways to achieve the goals in various settings and among various populations. The second phase is proposed to be completed in the fall of 2011 (Mulvale & Bartram, 2009). The final document in the second phase would provide a framework to align the strategic action

plans and foster recovery and well-being in Canada. Mulvale and Bartram summarized the feedback on recovery orientation from consultations with stakeholders in the first phase. Although there were different understandings about the concepts of recovery, recovery orientation was strongly supported by the MHCC council but raised the following concerns. First, recovery-oriented services must respond to the diversity of the social, political, and historical contexts of various groups of people. Second, some providers might be uncomfortable with the term “recovery” or not have a correct perception of recovery-oriented practices. Other concerns included the confusion over the meaning of recovery, the applicability of recovery concepts for children, youth, and elderly people, the accessibility of the services, and the availability of funding and resources (Mulvale & Bartram, 2009).

These Canadian concerns are similar to those of Davidson and colleagues in the U.S., who suggested the need to address ten concerns during the system transformation. The ten concerns included 1) recovery is old news; 2) recovery-oriented practice adds to providers’ burden, 3) recovery involves cure; 4) recovery happens to very few people; 5) recovery represents an irresponsible fad; 6) recovery happens as a result of active treatment; 7) recovery-oriented care can be implemented only through the addition of new resources; 8) recovery-oriented care is not reimbursable and evidence-based; 9) recovery-oriented care devalues professional roles; and 10) recovery-oriented care increases providers’ exposure to risk and liability (Davidson, O’Connell, Tondora, Styron, & Kangas, 2006). Policy makers should recognize and address the concerns in order to successfully transform the mental health system to one based on a recovery orientation.

Because the role and influence of the system-level decision makers has not been well studied, Piat, Sabetti, and Bloom (2010) conducted a qualitative study aimed at understanding Canadian decision makers’ perspectives on the transformation of services to a recovery-oriented practice within the mental health system. The participants represented three administration levels: policy makers at a provincial

level, senior administrators at a regional level, and senior administrators in large psychiatric facilities. The findings suggested that the decision makers agreed on the definition of recovery, viewed recovery approaches as more relevant to community-based services, supported the need for recovery education and the development of recovery outcome measures, and identified the importance of user involvement. The policy makers also described their role as establishing overall service orientation, while that of providers was to be responsible for recovery implementation. The authors concluded that decision makers play a powerful role in the mental health system with great influence on service delivery. Leadership therefore needs to acknowledge people's recovery potential and ensure people's equal opportunities to access recovery services (Piat, Sabetti, & Bloom, 2010).

Thus, to position recovery concepts at the centre of a mental health system requires the ongoing involvement of all stakeholders. Promoting active leadership, achieving consensus on recovery concepts, integrating resources, and addressing concerns about recovery-oriented practice would be key practices leading to the successful transformation of the mental health system.

In conclusion, many perspectives on and issues relating to recovery exist at the individual and system level, which have been extensively discussed and modeled in the literature. However, there is currently a gap within the literature regarding the actual practice of recovery-oriented services in the in-patient context. This thesis aims to address this gap by developing a recovery competency framework and a recovery education program specifically for in-patient providers. This overall literature review clarifies recovery concepts and provides background information for the thesis. Although there remains debate on various perspectives on recovery, this thesis mainly adopts the rehabilitation and consumer definitions of recovery. The reviewed recovery conceptual models and practice models are incorporated into the design

of the education program. In addition, taking the system level issues into account might increase the feasibility of the education program and broaden the scope of the thesis.

## Chapter 3

### Phase One: Competency Development

#### 3.1 Introduction

The notion of recovery has become a focus of mental health services in the past two decades. Recovery refers to the ways in which a person with a mental illness experiences and manages the disorder in the process of reclaiming his or her life in the community. Recovery-oriented services are what mental health providers offer in support of the person's recovery (Tendora & Davidson, 2006). Therefore, providers' understanding, beliefs, values, and attitudes are the key elements in the paradigm shift towards recovery orientation.

Recovery is a continuous and non-linear process, occurring even when an individual experiences intense forms of health services, such as hospitalization. Although recovery is largely conceptualized as movement towards a full and meaningful community life, a substantial number of people living with mental illness continue to experience hospitalizations in their recovery journey. Thus the in-patient setting has very real implications for people's recovery. However, the limited literature addressing recovery in in-patient settings suggests that these hospital stays may compromise the recovery process. For instance, short stays in hospital usually aim primarily at symptom stabilization while long stays can work against recovery by promoting passivity and deteriorating community living skills (Pratt, Gill, Barrett, & Roberts, 2007). Reports in the literature have also suggested that in-patient providers hold less positive attitudes toward recovery than community-based providers and are resistant to change towards a recovery orientation (Goodwin & Gore, 2000; Rickwood, 2004). The issues and challenges to delivering recovery oriented services in the in-patient context have not been subject to much direct research, and subsequently have been relatively poorly defined.



The development of recovery competencies has been used in the mental health system to assist in changing providers' ways of thinking and working to facilitate recovery at the individual level. Recovery competencies have potential to make recovery concepts more visible and tangible at the system level and the societal level (Schinkel & Dorre, 2006; Young, Forquer, Tran, Starzynski, & Shatkin, 2000). While there have been recent efforts to empirically identify a broad range of providers' recovery competencies that can be applied across different practice contexts, the development of specific competencies for delivering recovery-oriented services in the in-patient context has been lacking. To supplement this gap, this study examines the current in-patient context and proposes a recovery competency framework specifically tailored to the needs of in-patient providers.

## **3.2 Background**

In this study, *recovery competencies* are defined as attitudes, knowledge, skills, and behaviours a provider needs in order to offer recovery-oriented services to people with serious mental illness. Competencies define how providers are expected to assess, treat, and interact with service recipients. Unlike traditional competency sets which are profession specific and focus on clinical knowledge and skills, recovery competencies are grounded in a recovery philosophy and characterised by prioritising values, attitudes, and consumer participation (Coursey, et al., 2000; Schinkel & Dorre, 2006).

### **3.2.1 Existing recovery competency sets**

There are numerous competency documents that exist in the mental health field. However, only a few of them are recovery-focused. Coursey et al. (2000) and Young et al. (2000) identified competencies for community-based outpatient service providers. Both competency sets comprise a mixture of generic competencies basically required for all mental health providers and recovery specific competencies. The

methods they used for competency development included literature review and input from all relevant stakeholders through focus groups, key informant interviews, and panel discussion. Both competency sets stress the importance of individualized, holistic, and person-centered approaches. The common recovery competencies identified are fostering empowerment, diminishing stigma, involving family, understanding service recipients from bio-psycho-social aspects, accessing resources, and building collaborative relationships (see Table 3-1) (Coursey, et al., 2000; Young, Forquer, Tran, Starzynski, & Shatkin, 2000).

In 1999, the Ohio Department of Mental Health developed “The Recovery Process Model and Emerging Best Practices” which described the roles and responsibilities of consumers, clinicians, and community support workers. This is a comprehensive but complex model. The roles and responsibilities are organized in a matrix with two dimensions: nine components of recovery (clinical care, peer support & relationships, family support, work/meaningful activity, power & control, stigma, community involvement, access to resources, and education) and four stages of recovery (dependent/unaware, dependent/aware, independent/aware, and interdependent/aware) (Ohio Department of Mental health, 1999). The roles and responsibilities clearly delineate the competencies required for facilitating recovery. This was the first influential model addressing recovery specific competencies in the mental health field.

Subsequently, New Zealand’s Mental Health Commission published “Recovery Competencies for Mental Health Workers” in 2001 (O’Hagan, 2001). This document intended to incorporate a recovery framework in the New Zealand context and set up the recovery-based competencies required for mental health workers. The methods for competency development included a literature review, a review of New Zealand training standards for mental health disciplines, focus groups of services users, and written comments from relevant stakeholders. The document defines ten major competencies with three to five sub-competencies identified (see Table 3-1). This competency set is a general and broad framework that is suitable for all providers in New Zealand.

The fourth series of recovery competency sets was developed in Scotland. In 2006, Schinkel and Dorre first conducted a preliminary identification of recovery competencies specific to the Scottish context using literature review, focus groups with stakeholders, and interviews with educators (Schinkel & Dorre, 2006). Following their study, the NHS Education for Scotland worked with an expert group consisting of relevant stakeholders to produce a series of recovery learning materials that were intended to promote rights-based and recovery-focused mental health practices. One of the documents is “The 10 Essential Shared Capacities framework” that proposed capacities needed for all mental health providers in all practice settings (see Table 3-1) (NHS Education for Scotland, 2007a). Based on the 10 capacities framework, another framework called “Realising recovery: A national framework for learning and training in recovery focused practice” was developed outlining the knowledge, skills, and values mental health nurses required to deliver recovery-focused services. This framework more specifically proposed 25 knowledge requirements, 22 skills, and 20 values that workers need to have (NHS Education for Scotland, 2007b). Moreover, these Scottish competency frameworks are accompanied by learning modules and training programs that support providers in their development of recovery-focused competencies.

The Connecticut Department of Mental Health and Addition Services (DMHAS) published the “Practice Guidelines for Recovery-Oriented Behavioural Health Care” (second edition) in 2008 by the Yale University Program for Recovery and Community Health. This framework addresses 6 domains which comprise generic recovery competencies required by all mental health providers and provides a practical direction for providers to implement recovery-oriented services. The 6 domains illustrate recovery-oriented care as 1) consumer and family driven; 2) timely and responsive; 3) person-centred; 4) effective, equitable, and efficient; 5) safe and trustworthy; and 6) maximizing use of natural supports and settings (Tondora, Delphin, Andres-Hyman, O'Connell, & Davidson, 2008).

Table 3-1 describes the competency documents discussed above (except the complex Ohio model), organized according to attitudes, knowledge, skills, and behaviours. They comprise several common recovery principles, such as respectful relationships, knowledge of mental illness, strength-based approaches, consumer and family participation, and advocacy. They are comprehensive and applicable in different mental health service delivery settings.

Another category of competencies related to this study are those specific to acute mental health care. The NHS Education for Scotland developed “A capability framework for working in acute mental health care” describing the values, skills, and knowledge nurses need to deliver high quality acute care within hospital settings and community settings such as crisis resolution teams, crisis centres, and intensive home care and treatment. This framework includes four areas: 1) rights, values and recovery focused practice; 2) supporting recovery from acute crisis; 3) making a difference in acute care; and 4) sharing positive risk taking (NHS Education for Scotland, 2010). In comparison to generic recovery competency sets discussed above, this framework particularly pays attention to the acute mental health care in terms of patients’ rights, recovery, relationships, and environment. Because acute care in Scotland includes crisis resolution teams, crisis centres, and intensive home care mostly in the community settings, the focus of the framework is different from this study which emphasizes the in-patient context.

**Table 3-1 Review of current recovery competency frameworks**

Category	<i>Coursey, et al., 2000</i>	<i>Young, et al., 2000</i>	<i>New Zealand, 2006</i>	<i>Scotland, 2007</i>	<i>DMHAS, 2008</i>
Attitude	-engaging people with dignity and as full collaborators in service delivery -including family members and caring others in service delivery	-clinical relationship: respect, accessibility, communication, minimizing stigma -relationship & empowerment: optimism, holistic -family involvement and support system	-recognizing and supporting personal strengths and resources -developing good and respectful relationships with service users -supporting service users' participation and advocacy -supporting family participation	-working in partnership -respecting diversity -challenging inequality -promoting recovery	-consumer and family driven -person centred
Knowledge	-demonstrating current knowledge related to mental illness -demonstrating current knowledge of the biological aspects of SMI -knowing and using best practices and support strategies -being knowledgeable about legal issues and civil rights	-social & cultural knowledge, cultural specificity	-understanding recovery principles and experiences -understanding and accommodating the diverse views of mental illness -acknowledging different cultures	-personal development and learning	-maximizing use of natural supports and settings
Skill	-providing individualized services and support -effectively accessing and employing community resources - collaboratively working within and across the service system -being culturally competent -improving outcome	-initial and ongoing assessment -treatment -resources and coordination of care	-supporting the use of community services and resources	-identifying people's needs and strengths -providing service user-centre care -making a difference -promoting safety and positive risk taking	-timely and responsive -effective, equitable, and efficient
Behaviour	-behaving in a professional and ethical manner		-understanding and protecting service users' rights -understanding and reducing social discrimination and exclusion	-practising ethically	-safe and trustworthy

### 3.2.2 The in-patient context

Since the mid-1960s, Canadian mental health policies have moved from hospital-based care to greater emphasis on community-based mental health care. This has meant the downsizing and/or closures of psychiatric hospitals and the increase of community-based services (Mulvale, Abelson, & Goering, 2007). In Ontario, this move to community-based service delivery is demonstrated through the broad diffusion of evidence-based Assertive Community Treatment and by development of Ontario Federation of Community Mental Health and Addition Program (OFCMHAP), federation of over 200 community mental health programs. Because of this shift to community care, the nature of in-patient care has changed dramatically, with patients admitted to acute in-patient units in extreme distress and vulnerable status (Dewis & Harrison, 2008). At the time of distress and vulnerability, patients are especially in need of quality services that help them regain a sense of control in their lives. In addition, although the number of long-stay patients in tertiary psychiatric hospitals declined during the past three decades, a group of individuals still requires some form of in-patient care. In-patient settings continue to serve a significant function in the mental health system and remain a critical part of patients' recovery.

In this study, *in-patient settings* include acute and long-term units in tertiary care hospitals specializing in the treatment of mental illness. Traditionally, there have been restrictions on patients' freedom of choice in these settings. There are also challenges related to the interactions with the in-patients themselves, including for example, threats, unpredictability, acute mental disturbance, and the chronicity of mental health conditions. These challenges are associated with a need for heightened sensitivity and preparedness at all times. Some studies have revealed that in-patient providers attempt to master the ward situation and maintain ward stabilization by means of rules and routines. Some kinds of controls are seen as parts of the treatment, for example, the use of behavioural contracts to prevent destructive behaviours. Some controls are seen as protection, for instance, searching through people's belongings for dangerous objects (Hummelvoll & Severinsson, 2001; Johansson, Skärsäter, & Danielson,

2006). However, achieving balance between interventions that are believed to be beneficial and patient choice can result in many ethical tensions in the in-patient setting. Distinctions among ethical issues, legal concerns, safety, and patients' rights could produce tensions, which are magnified in the in-patient wards (Cleary, 2003; Cleary, 2004; Hummelvoll & Severinsson, 2001; Johansson, Skärsäter, & Danielson, 2006).

In acute in-patient settings, perhaps primarily because of the short length of stay, e. g. average 14 days in 2004-2005 in Canada excluding Quebec (Canadian Institute for Health Information, 2005), the demand for treatment effectiveness mostly relies on medication. The need for a quick and effective outcome promotes the application of the medical model. Under the medical model, a large majority of the treatment related discussion is based on symptoms, pathology, and medication (Hummelvoll & Severinsson, 2001). Consequently, emphasis on symptom reduction and problem-oriented interventions may overshadow the holistic philosophy and recovery principles.

With the changing needs of the services, in-patient providers require specific knowledge, skills, attitudes, and behaviours to effectively engage patients in need of acute or intensive levels of care. The development of a recovery competency framework for in-patient providers is imperative to reflect on the unique tensions and to address how a recovery-orientation can be delivered in the in-patient context.

### **3.2.3 Competency development**

A competency model consists of a list of competencies and is organized by categories with a clear definition and some examples. All these components should be tailored specifically to the context in which they would be used (Hoge, Tondora, & Marrelli, 2005; Marrelli, Tondora, & Hoge, 2005). The empirical development of a competency set can involve five steps: 1) define performance effectiveness criteria; 2) collect data; 3) analyze data and develop a competency model; 4) validate the competency

model; and 5) prepare application of the competency model (Spencer & Spencer, 1993). Roe (2002) also proposed four steps to develop a competency profile for any occupation. They are 1) occupational or job analysis, including collecting information on the role and duties to be performed in a job; 2) competency analysis such as identifying required knowledge, skills and attitudes, as well as underlying characteristics like personality traits; 3) competence modeling which develops a model showing the relationships among particular competencies; and 4) testing the competency model (Roe, 2002). In 2005, Dewing and Traynor conducted an action research project aimed at working collaboratively with nurses to facilitate the development of a specialist competency framework. They combined two complementary research approaches, the emancipatory action research and systematic practice development, in five phases of competency development: scoping exercise, sharing findings from scoping exercise, developing the content and structure, piloting a draft version, and setting the scene for implementation (Dewing & Traynor, 2005). In addition, Mulvale (2005) emphasized the importance of the complex context in which the competency framework will be carried out. The development of competencies needs to involve all stakeholders and address their concerns to increase the framework's credibility (Mulvale, 2005). The above models and principles of competency development provide methodological support for the current study.

The purpose of this study is to assess in-patient providers' recovery educational needs and identify the most salient components of recovery competencies. The research questions addressed here include, "What are the most salient components of recovery competencies required for providers working in in-patient programs in psychiatric hospitals?" and "What do providers need to change from the current practice to recovery-oriented services?" The newly developed recovery competency framework will serve as a basis for tailoring workforce education to prepare in-patient providers for recovery-oriented practice.



### **3.3 Methods**

The competency development strategies reviewed in the previous section were used in this study. It is important to involve all stakeholders, including patients, significant others, mental health professionals, and managers, to increase the framework's credibility (Mulvale, 2005). The current study aims to assess the in-patient context and develop a competency framework. The particular challenges facing in-patient providers in delivering recovery-oriented services were derived from two sources: the literature review and key informant interviews, which are two major data collection methods used to develop recovery competency sets (Coursey, et al., 2000; O'Hagan, 2001; Schinkel & Dorre, 2006; Young, Forquer, Tran, Starzynski, & Shatkin, 2000). The recovery competency would be then developed accordingly. The proposed action to improve current situations, that is, the development and implementation of the recovery educational program is conducted in the next phase of the study.

This study involves four major steps: Step One is the literature review; Step Two is the key informant interviews; Step Three is data converging and analysis; and Step Four is competence modeling.

#### **3.3.1 Step One: Literature review**

To conduct a literature review concerning the current in-patient context in relation to recovery-oriented practice, searches were performed in the MEDLINE, PsycINFO, EMBASE, Health and Psychosocial Instruments, and Google databases, using the following search terms: *recovery-oriented service, in-patient, hospital, ward, acute psychiatry, long-term, long-stay, rehabilitation, therapeutic milieu, mental health professionals, competency, engagement, and therapeutic relationship*. The searches were limited to English language articles published from 2000 onwards. Because the concept of recovery was first introduced by Patricia Deegan in 1988, and an initial shift in focus toward recovery-oriented practice in the mental health field occurred in the 1990s, searches were limited to the past decade in order

to access state-of-the-art data and information on the most current developments in recovery oriented services. Articles dealing specifically with children, adolescents, substance abusers, and the elderly were excluded because the focus of this study is adults with serious mental illness. The literature review addresses the following issues: 1) the therapeutic environment and culture of in-patient settings; 2) in-patient providers' recovery competencies; and 3) the challenges or barriers for providers to develop recovery competencies and deliver recovery-oriented services.

A total of 32 papers are included in the review and are summarized in Table 3-3. These 32 articles present stakeholders' perspectives regarding in-patient services and consist of sixteen qualitative studies, seven survey studies, one mixed method study, four personal accounts, three literature reviews, and one general article.

### **3.3.2 Step Two: Key informant interviews**

The objective of the interviews was to find the most salient components of recovery competencies in in-patient psychiatric settings. In order to meet this objective, the following people were recruited as interviewees: 1) three consumers with serious mental illness, who have had previous in-patient experience in the last two years; 2) three family members who have a close family member who is diagnosed with serious mental illness and was admitted as an in-patient to a tertiary care mental health facility in the last two years; 3) two community mental health providers who have previous experience working in in-patient programs; 4) five in-patient providers who currently provide clinical in-patient services, are from different disciplines, and have worked in tertiary care mental health facilities in Ontario for at least two years; and 5) two educators who have a mandate to promote recovery oriented services and are in strategic positions in workforce training in these tertiary care mental health facilities. An effort was made to ensure the

diversity and representativeness of the stakeholders. For example, providers from different disciplines were recruited to get a variety of perspectives of clinical experiences and educational needs.

After receiving ethical approval from Queen's University Health Sciences Research Ethics Board, Providence Continuing Care Centre Research Review Committee, and the Centre for Addictions and Mental Health Research Ethics Board, the study's recruitment process began (see Appendix A and B). The consumer interviewees and family interviewees were recruited through Frontenac Community Mental Health Services. The provider interviewees were identified by key persons working within two Ontario tertiary care mental health hospitals. Prior to the interviews, the participants were informed of the purpose of the research and their rights as participants, and completed the consent process (see Appendix F). The interviews were semi-structured and individual, and occurred face-to-face. At the beginning of the interviews, the participants were briefly introduced to the concepts of recovery and recovery competencies. Then they were asked to discuss their views of recovery and the recovery competencies that they believed to be most important to in-patient providers. Consumers and family participants were also asked about their expectations of providers. In addition, all participants were asked to discuss particular challenges providers may face in demonstrating recovery competencies. All participants were encouraged to freely express their opinions about the subject. Appendix G shows the interview protocol that was used to guide the interview process. Each interview was audio recorded and lasted for 30 to 70 minutes.

### **3.3.3 Step Three: Converging and analyzing data and Step Four: Competency modeling**

The interview data were transcribed verbatim. The first step of the data analysis was to read through the transcripts to obtain a sense of the overall meaning of the in-patient context for each participant. The next step was to code one transcript from each category of participants line by line to extract significant

statements related to recovery and provider competencies. Then the codes were reviewed by the investigator again and clustered into groups. In the third step, findings from the literature review were integrated into the groups of codes. Analysis of categories for higher meanings led to the development of two themes: one was related to tensions, barriers, and challenges embedded in delivering recovery-oriented services in the in-patient context; the other was related to in-patient providers' recovery competencies. After refinement of the themes, in the fourth step, a preliminary "tension-practice-consequence" conceptual framework was developed to organize the first category of themes (tensions) and explain their relationships. The fifth step was to analyze the remaining transcripts and add new findings into the conceptual framework. In this step, data were compared to the literature to find similarities and differences. Then the final tension-practice-consequence framework was completed. In the sixth step, based on the tension-practice-consequence model, the second category of themes (provider competencies), and the literature review, another conceptual framework was developed to address the tensions and explain the processes of enabling providers in delivering recovery-oriented services. The same effort was taken to compare the data and refine the enabling framework.

Processes for building trustworthiness included: 1) expert scrutiny: the investigator and the thesis supervisor coded a transcript and compared findings to support the credibility of the data analysis; 2) frequent debriefing sessions: the investigator discussed the data analysis with the thesis supervisor, who helped the investigator recognize potential bias, broaden the vision, and draw attention to different perspectives; 3) self-reflection: the investigator used the reflective commentary to record the impressions of each transcript and patterns appearing to emerge in the data interpretation. In response to the dominance of negative interpretations emerging at the beginning of data interpretation, the investigator went back to the original data to ensure multiple sides of perspectives were taken into account; and 4) advisory committee: three advisory committee members who are expert in the qualitative research

reviewed the findings and provided suggestions in order to ensure trustworthiness of the data interpretation.

The fourth to sixth steps were the process of competence modeling. According to Roe, a competency set is defined as “a list of competencies, sub-competencies, knowledge, skills, attitudes, abilities, personality traits and other characteristics that are essential for carrying out a job or an occupation” (Roe, 2002, p. 197). Building a model is essential to demonstrate the relationships between each competency. These steps established two models. The first model, the tension-practice-consequence model, delineated the relationships between particular tensions in delivery of recovery-oriented services in the in-patient context. The second model is a corresponding model illustrating the recovery enabling process. Finally, the final core competencies and sub-competencies were identified and positioned into the enabling framework.

### **3.4 Findings**

A total of 15 participants were interviewed. They consisted of 3 consumers, 3 family members, 7 providers from 5 different disciplines, and 2 educators (see Table 3-2). To illustrate the themes, direct quotations by the participants are included. Table 3-3 lists the reviewed papers. Study findings are based on the integration of the interview data and the literature review.

**Table 3-2 The participant profile**

Participant # code	Category- Discipline	Sex	Practice setting	Years of experience
5	Consumer	M		
6	Consumer	M		
7	Consumer	F		
13	Family	F		
14	Family	F		
15	Family	F		
1	Provider- Occupational therapist	M	In-patient (site 1)	2
3	Provider- Social Worker	F	In-patient (site 1)	3
4	Provider- Nurse	M	Community (site 1)	15+
8	Provider- Social Worker	F	Community (site 2)	2
9	Provider- Nurse	F	In-patient (site 2)	10
11	Provider- Psychiatrist	M	In-patient (site 2)	8
12	Provider- Psychologist	F	In-patient (site 2)	29
2	Educator	F	Management (site 1)	20+
10	Educator	F	Management (site 2)	26

**Table 3-3 Reviewed articles**

Author, year	Research purpose	Study design/context	Findings relevant to this study	Dimensions
Alexander, 2006	Explore patients' response to ward rules and its impact on nurse-patient relationships	Mixed method study design (interviews and measures of ward atmosphere...)/ 30 patients and 30 nurses within two acute psychiatric wards	1) Patients felt that their psychosocial problems were neglected; 2) Lack of information and flexibility engendered patients' anxiety, fear, and confusion; 3) Lack of opportunity for patient involvement was found; 4) Patients felt that their dignity was stripped.	-Environmental level tensions -Provider's own tensions
Alexander & Bowers, 2004	Explore psychiatric ward rules from the perspective of nurses and patients	Literature review/ psychiatric inpatient ward	1) Because literature had divided opinions, the finding cannot conclude whether rigid or flexible environments are beneficial; 2) The boundaries between the treatment of psychiatric disorder and the behavioral control are often blurred; 3) Nurses' approach during rule imposition is important in the prevention of aggression; patients may view the rules positively if they perceive being cared for.	-Environmental level tensions -Provider's own tensions
Brimblecombe, Tingle, & Murrells, 2007	Investigate how mental health nursing can improve service users' in-patient experiences and outcomes	Survey research/ A total of 257 responses of stakeholders	There is a desire for: 1) service user engagement in service design; 2) service user involvement in their own care; 3) therapeutic engagement in activities; 4) a safety and caring environment; 5) continuity of care; and 6) providers training.	-Environmental level tensions -Provider's own tensions - Engagement -Transition
Cairns, et al., 2005	Determine the prevalence of in-patients who lack decision - making capacity	Semi-structural interviews using a measurement tool/ 112 psychiatric in-patients	43.8% of the participants lacked treatment-related decision capacity which was associated with psychotic symptoms, cognitive impairment, poor insight, or ethnicity.	- Personal level tensions
Chickwana, 2007	Share the experience of an in-patient provider	Nurse's personal account/ acute ward	1) The medical model is the most influential perspective; 2) Communication tends to be top-down; 3) The caseload is overwhelming; 4) Positive parts included getting support, feedback, and professional development.	-Provider's own tensions -Medical model

Author, year	Research purpose	Study design/context	Findings relevant to this study	Dimensions
Cleary, 2003	Understand how nurses construct their practice in the context of service reforms	Ethnographic study/an acute in-patient psychiatric unit	1) In acute in-patient care, a real partnership is not easy to achieve because of the challenges related to power and control and lack of consensus between patients and staff; 2) Nurses faced challenges in balancing the role of therapy with the role of control and in protecting patients in a way that support their rights and dignity.	-Environmental level tensions -Provider's own tensions
Cleary, 2004	Understand how nurses construct their practice in the context of service reforms	Ethnographic study/an acute in-patient psychiatric unit	Nurses perceived constant pressures from unpredictability of the ward situation, threat of patients, high workplace demands, and heavy workloads. These pressures prevent nurses from fulfilling their own expectations for a professional role.	-Provider's own tensions
Currid, 2009	Explore the lived experience of stress for nurses	Hermeneutic phenomenological study /four acute mental health settings	Nurses are subjected to high level of stress and pressures which may lead staff to be reluctant to engage with patients.	-Provider's own tensions
Duggins, 2007	Share the experience of an in-patient provider	Junior psychiatrist's personal account/ acute ward	1) The provider shared a feeling of helpless, overwhelmed, exhausted, and frustrated, which caused him to "withdraw into a protective shell"(take the easy option, follow rules to survive); 2) Patients were not encouraged to discuss their feelings.	-Provider's own tensions -Medical model
Forchuk & Reynolds, 2001	Examine the therapeutic relationships between nurses and patients in Canada and Scotland	- Canada: interviews with nurses and patients/a tertiary care psychiatric facility - Scotland: 30 patients' statement /acute psychiatric units	Patients identified the relationships with nurses as important to their recovery. They wanted nurses to be listening, available, friendly, sensitive to their feelings, helpful, and offering suggestion without taking control.	- Relationship
Gilburt, Rose, & Slade, 2008	Understand users' experience of hospitalization	User-led participate action research using focus groups and interviews/ 19	Relationships formed the core of patients' experience. Barriers to positive relationships included ineffective communication, a lack of sense of trust and safety to providers, environmental factors.	-Environmental level tensions -constrained communication - relationship



Author, year	Research purpose	Study design/context	Findings relevant to this study	Dimensions
Goodwin & Gore, 2000	Explore stresses of nursing staff	Observation/ long-stay psychiatric ward	1) Nurses showed anti-task behaviors and limited their emotional engagement as a defensive structure to protect them from anxieties; 2) Nurses' fundamental anxieties came from patients' mental disability, disturbance, and chronicity.	- Personal level tensions -Providers' own tensions
Howard, El-Mallakh, Rayens, & Clark, 2003	Investigate satisfaction with in-patient services and treatment outcomes	Survey design/ 204 hospitalized patients from 2 hospitals	Patients reported overall satisfaction. Areas of dissatisfaction included exclusion from treatment planning, lack of family involvement, and lack of medication education.	- limited engagement
Hughes, 2007	Share the experience of an in-patient provider	Occupational therapist's personal account/ in-patient rehabilitation ward	1) The provider experienced professional tension such as lack of support from other disciplines; 2) It is frustrating to spend hours preparing for groups, but find that only a few clients willing to attend.	- Personal level tensions -Providers' own tensions
Hummelvoll & Severinsson, 2001	Understand the complexity of the acute psychiatric ward and the way nurses balance their tensions	Descriptive and explorative qualitative design with participant observation/an acute psychiatric ward	Nurses' stress included the acute and unpredictable characteristics of the ward, short-stays of patients, and the conflict between effectiveness/ professional and humanistic ideals. The demand for effectiveness promotes a medical model.	-Personal level tensions -Provider's own tensions -Medical model
Jenkins & Elliott, 2004	Explore stressors and burnout of nurses	A survey design / 93 nursing staff from acute adult mental health wards	Stressors of nursing staff included lack of resources and adequate staffing, dealing with physical threatening, and difficult or demanding patients.	-Provider's own tensions
Johansson & Eklund, 2003	Investigate patients' opinions on what constitutes good psychiatric care	Phenomenological research using open-ended in-depth interviews/ 7 outpatients and 9 inpatients	1) The provider-patient relationships formed the central aspects of good care; 2) Patients need to feel validated, supported, and stability, and want increased activities and opportunities	-Environmental level tensions -Provider's own tensions - relationship
Johansson, Skärsäter, & Danielson, 2006	Describe the health-care environment on a locked psychiatric ward	Ethnographic study/a locked, acute psychiatric ward	1) The environment was overshadowed by control; 2) There was an unacceptable imbalance in power between patients and staff; 3) the staff were exposed to pressure and threats from patients.	-Environmental level tensions -Provider's own tensions

Author, year	Research purpose	Study design/context	Findings relevant to this study	Dimensions
Jones, et al., 2010	Explore the experience of service users on acute in-patient psychiatric wards in England	Semi-structured interviews (the qualitative part of a large mixed methods study)/ 60 hospitalized services users	Some service users felt safe and cared for in hospital while others perceived psychiatric wards as risky environments because of aggression, bullying, theft, racism and the use of alcohol and drugs on the ward.	-Environmental level tensions
McCann, Baird, & Lu, 2008	Describe professionals' attitudes towards consumer participation	Survey/47 professionals from an adult acute in-patient units and a secure rehabilitation unit	Professionals showed paradoxical attitudes towards consumer participation: the favorable attitudes in matters indirectly related to their role and responsibility, and the disagreement in matters threatened to professional authority.	-Provider's own tensions
MIND, 2004	Understand conditions in in-patient units from patients' perspectives	Survey, focus groups/ 335 patients who at the time they completed the questionnaire had been inpatients in the past two years	27% of the respondents rarely felt safe while in hospitals; over 50% had experienced verbal and physical threat during their stay; Patients' dissatisfaction with their hospital experience centred on problems with the physical environment, boredom, under staffing and staff attitudes.	-Environmental level tensions -Provider's own tensions
Moyle, 2003	Understand the importance of therapeutic relationship	Phenomenological research using interviews/ 7 depressed patients from a private psychiatric hospital	1) Being nurtured: provide an initial orientation and a feeling of safety; 2) Not being nurtured: (providers) hold the power in treatment, neglect their emotional needs, focus on their symptoms, and do not effectively communicate with them	-Provider's own tensions
Norton, 2004	Identify ways of constructing therapeutic milieus	Literature review/acute psychiatric inpatient care	Five key therapeutic functions of the ward environment: containment, support, structure, involvement, and validation. Four destructive processes: isolation, poor team function, staff factors, and structural manifestations in the ward.	-Environmental level tensions -Provider's own tensions
Oeye, Bjelland, Skorpen, & Anderssen, 2009	Explore how to implement user participation in a long-term ward	Ethnographic study/ a long-term psychiatric ward	Three tensions were found when there is difference between 1) individual needs and collective rules, 2) patients' viewpoint and staff judgments, and 3) patients' and staff's power or hierarchy	-Provider's own tensions -Environmental level tensions

Author, year	Research purpose	Study design/context	Findings relevant to this study	Dimensions
Preti, et al., 2009	Analyze the characteristics of patients and patterns of in-patient care	A national survey/ 1330 patients discharged from public and private inpatient facilities in Italy	Rehabilitation and psychotherapy were rarely initiated during the hospital stay because of aggressive pharmacological treatment strategies for rapid symptom remission, the belief of non-beneficial of psychosocial intervention for inpatients over a short time span, or the shortage of staff.	-Environmental level tensions
Robert, Hardacre, Locock, Bate, & Glasby, 2003	Explore service user involvement in design of in-patient services	Action research study/ six mental health trust sites	1) Service user involvement is a strength and benefit of the mental health services; 2) The particular challenges in the specific context of acute mental health services, such as power difference, the tension between caring and custody, should not be overlooked.	-Environmental level tensions -Provider's own tensions -Engagement
Shattell, Andes, & Thomas, 2008	Explore the experience of patients and nurses	Phenomenological study/an acute care psychiatric unit	1) Nurses and patients were confined and intimidated; 2) Patients' needs were not met; 3) There is no mutual support between patients and nurses	-Environmental level tensions -Powerless/ relationship
Short, 2007	Share the in-patient experience	Consumer's personal account	The consumer shared the feeling of insecurity and being invalidated, blackmailed, and misunderstood.	-Environmental level tensions -Provider's own tensions
Smith & Bartholomew, 2006	Discuss how a recovery model can be implemented in the hospital context	General article/State psychiatric hospitals, USA	1) Four components of recovery from a hospital perspective: hope, self-identity, meaning in life, and responsibility; 2) Challenges: the dominance of medical model, hierarchical structures, staff attitudes that tend to resist changes, and the effects of institutionalization .	-Environmental level tensions -Personal level tensions -Provider's own tensions -Medical model
Tay, Pariyasami, Ravindran, Ali, & Rowsudeen, 2004	Explore the factors influencing nurses' attitude and involvement	Use a descriptive, self-administered questionnaire/ 409 nurses in a psychiatric hospital	Nurses working in the long-stay ward had less positive attitudes toward people with mental illness, because they were not able to see patients returned to the community or they received less support from other providers.	-Provider's own tensions

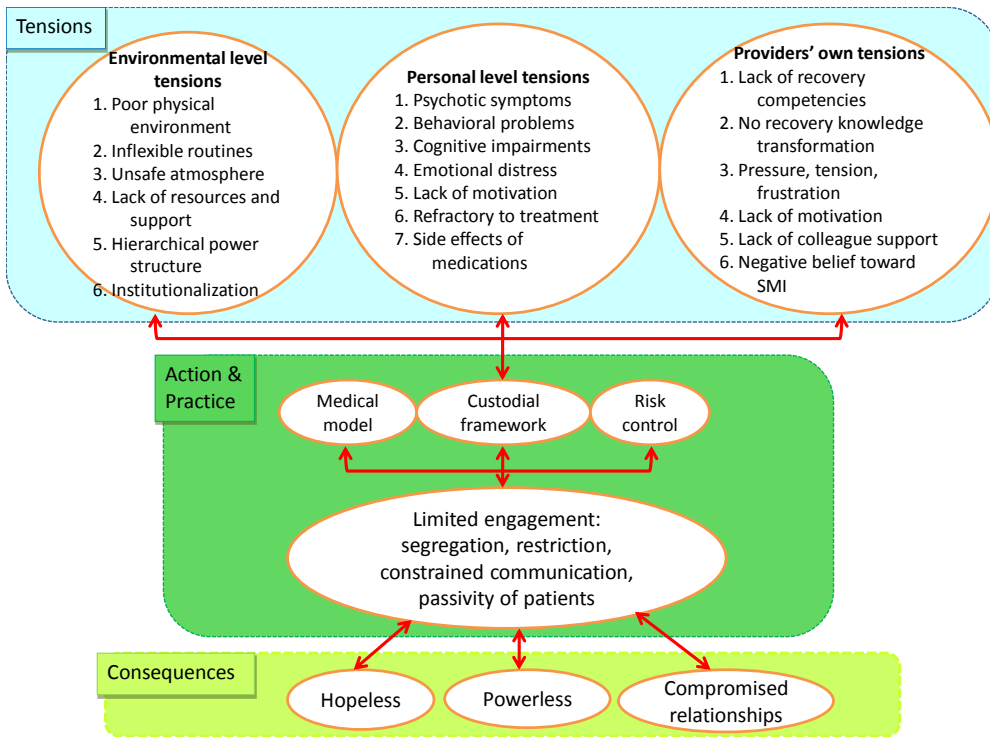
Author, year	Research purpose	Study design/context	Findings relevant to this study	Dimensions
Thomas, Shattell, & Martin, 2002	Explore patients' experience of the in-patient environment	Phenomenological study using interviews/ 8 in-patients on an acute psychiatric unit	1) Hospital is a refuge from self-destructiveness; 2) Patients need self-identity, orientation toward future, good relationships with others; 3) Patients described bad staff as uncaring, withholding, too professional, and not respectful.	-Environmental level tensions -Provider's own tensions
Varley, 2007	Share the experience of encounter with in-patient services	Family member's personal account	The family member felt upset, angry, and frustrated due to the negative experience such as lack of information, poor staff attitude, and hierarchical system.	-Environmental level tensions -Provider's own tensions

### 3.4.1 The in-patient context

The concept of “tension”, as used in this study describes challenges embedded in delivering recovery-oriented services. Tensions refer to moments or situations where practice that is consistent with recovery ideals is strained, or not easily reconciled. The findings from this study identify several points of tension in the delivery of in-patient services that challenge the consistent delivery of recovery-enabling services. These points of tension are described as possible barriers to the recovery vision in the in-patient context and organized as environmental level tensions, personal level tensions, and the providers' own tensions. These tensions compromise recovery-enabling services through their potential to lead to routine and uncritical application of the medical model, a custodial framework, and risk-control principles in practice. This generates the in-patients' sense of segregation and restriction, limits choices and constrained communication, and causes passivity. As a result, hopelessness, powerlessness, and poor relationships between providers and in-patients can result.

A tension-practice-consequence model illustrated in Figure 3-1 elucidates the current in-patient context in relation to recovery-oriented services. All factors illustrated in the model have mutual

relationships. Thus the consequences may negatively reinforce the practice, and the practice may increase the level of barriers.



**Figure 3-1 The tension-practice-consequence model: Tensions inherent in delivering recovery-oriented services in the in-patient context**

### 3.4.1.1 The tensions

#### 1. The environmental level tensions

A number of environmental factors which present significant tensions to recovery are found through the interview data and eighteen reviewed articles (see Table 3-3). They are 1) non humanistic physical environment; 2) unsafe atmosphere; 3) inflexible ward routines; 4) lack of resources; 5) hierarchical power structure; and 6) institutionalization.

The physical environment of the in-patient setting is often described as being non-humanistic, non-healthy, discouraging, and lacking stimulation. As a consumer participant stated, “In the hospitals ... it’s just that you’re in like a big room full of beds and there’s like one hallway, and like a TV room ... that’s all there is...” (#6). An educator participant provided a similar description of the physical layout:

I think you know the first thing when you just walk on to the unit. What are the signs you see? ... They have all bars on the wall to separate where the stairs are from where people eat, so it has a feeling of looking like a little bit of a jail. That is not recovery. The walls are of a cinder block and there is all kind of signs to say, hey, wall, watch out for this client, he could escape.... That is not recovery-oriented, the physical layout. Are there places for people to sit? Are there gaming and activities, computers for people to use? And some programs do not have enough of those. (#10)

People receiving care in in-patient settings are described as vulnerable to bullying, extortion, or intimidating behaviors. The atmosphere is characterized as being tense and unsafe. In the literature review, four articles found that patients perceived the in-patient environment as unsafe. A consumer participant characterized the environment as “a rough place like there would be a couple of fights every day” (#6). He also described the fear resulting from the intimidating behaviors of other patients:

This guy would pick on like anybody like little guys, ... like sick people, people that couldn’t defend themselves, like he was in there for beating up a 12-year-old kid ... or something like that.... We have a guy like that on the ward, like a lot of the people are, they’re scared, and they’re all intimidated.... They can’t feel comfortable. I mean they’re always worried.

A family participant expressed concerns that her daughter was threatened by some of the other in-patients and expected that providers should deal with these conflicts, resolve negative feelings, and play the role of mediator:

There was reason for my daughter to be frightened and I understood why she was frightened, there were some men there who said frightening things to her.... She was really, really scared while she was there of these people.... I think she did [talk to the staff] but she didn’t get a satisfactory response. (#13)

Lack of privacy related to even the most personal self-care routines, compromising patients' dignity.

An educator participant commented on shower time in the ward:

Not all people want to take a shower in the morning, not all people want to get up. So that is the problem. They all line up and get it at the same time. And the [providers] are asking how are you? How are you? But the privacy and the lack of privacy is the barrier. (#10)

In the in-patient setting, tensions exist between maintaining the order and ensuring patients' choices, control, preferences, and satisfaction. Ward rules, routines, and regulations are perceived as rigid with respect to what activities are permitted, and restricted with regards to the time and space for these activities. One provider participant noted:

Showering routines are a certain period of time during the day. And so just the other day, I observed somebody asking if they could take a shower in the afternoon and [provider] said no... There's not much give or flex ... really strict with med schedules and meals and showering and a bunch of things, even laundry and other things as well. There isn't as much choice. (#1)

An educator participant remarked that:

The challenges are that there are so many rules and routines in an in-patient setting. People don't have the same sense of control ... on an in-patient setting. People have that loss of autonomy ... so many things were done for them or done to them ... like there's some restrictions around when, what days people can bathe, what days people can't. ... So there's that kind of structure.... Meds are given out in certain time. For locked units you can only come and go to smoke at certain times. So there're a lot of restrictions. (#2)

The rules and regulations can lead to a feeling of powerlessness. A power imbalance between providers and patients is clearly revealed.

Providing choices and freedoms outside of the in-patient structured routines presents a challenge for in-patient settings. From providers' perspectives, structured routines are established as the means to provide safety and security of patients who are experiencing acute conditions. Rules and routines are viewed as necessary to maintain order, to decrease risk of harm, and to ensure that individuals served are taking care of themselves. The acuity of the mental illness while in hospital challenges the recovery focus

on empowerment, autonomy and choice by raising concerns about the competence and capacity for the freedoms associated with flexible routines, and about the perceived accountability of the in-patient setting: “There is no way because they cannot make the decision for themselves and ... that’s why we have to limit them.” (#9)

Flexibility and choice are offered for matters that are not seen as directly related to safety:

Restriction is there. Some of them, they cannot go out of unit. But we can go to the other environment like the hall. We can improve on their education. And still we can give them choice for other matters.... For example, they cannot choose their medication because they have lots of issues they may get. They cannot spend their money the way that they want because other people there might steal their money, but in their food ... what kind they want ... what recreation they want, we can work on this part ... other parts that they can have choices. That they feel better about their lives. (#9)

The other environmental tension is a lack of resources. Consumer participants reported strong feelings of segregation in in-patient settings and lacking in opportunities to access community resources. They wish to have contact with the outside world. Consumer participant #5 stated his expectation: “just ... getting people out into the community, getting them out to ... a farm or getting them out on walks or ... to see a zoo or animals”. Consumer participant #6 shared a positive experience about a student the hospital hired to provide some activities over the summer. He stressed that these kinds of community resources are essential not only in summer but all year round: “When she brings in a couple of balls and we’re ... playing games and bringing crafts all the stuff, brings in like ... cards, brings in monopoly, brings in all the stuff to you, it’s like it’s good” (#6).

Resources also take the form of opportunities for engagement in activities. In-patient environments are characterized as bereft of activity and of the materials to engage in activities, and associated with experiences of boredom. Consumer participant # 6 described his in-patient experience as lacking in activities and “walking up and down an empty hallway ... with nothing to do” for four months. He expressed his desire to do more things.



Materials and equipment available for activities were described as in poor condition and unlikely to encourage participation. A consumer participant reported that all the magazines, board games, and reading materials were very old, out of date, or missing pieces: “All the games we have were like, like all the pieces weren’t there. So you couldn’t even play them you know and then there is like I say old books and like nobody wants” (#5). This situation reinforces the feeling of segregation and despair.

The next environmental tension identified is the hierarchical power structure in the hospital context in which decision-making and communication tends to be top-down. For example, in the in-patient setting the doctor’s opinions take precedence over those of nurses or patients (Chickwama, 2007). One consumer participant referred to the in-patient experience as “suffering” because providers did not pay them enough respect (#6). This experience makes patients vulnerable to power. Another consumer participant gave an example describing his traumatic experience:

Each individual has doctor’s orders ... and they have to earn those privileges.... You’re a patient and you want to utilize this order, and all of a sudden you got to do it and say it’s the weekend ... and then this nurse will say why, you can’t do that ... the doctor’s order hasn’t been written. And they do it with an attitude. They tell you with attitude.... So, you have been subjected. It’s not so much what they do. It’s the way they do it. It’s the attitude and the verbal abuse and the attitude behind it. (#5)

Patients are vulnerable to feeling attacked and hurt by providers because of the power imbalance that is expressed through provider language and behaviors. Consumer participant #5 described providers in this way: “There’s one, sort of like guards, they come in there and they just like to power trip and show their attitude and make people’s lives miserable.” None of the provider participants addressed the issue of power in their interviews, but they did comment on the importance of respect.

The final environmental tension is the experience of becoming institutionalized which could be caused by long-term stays in hospital or frequent readmission. Dependence on the hospital, submission, passivity, and decreasing activity engagement are all consequences of institutionalization which frustrate

providers when they try to move patients forward into recovery. A provider participant described her worry:

These patients are more in and out, in and out, and in and out, and they are more institutionalized. They get used to the hospital environment.... They cannot take care of themselves and then usually some of them, they have somebody to make a decision for them. (#9)

## 2. The personal level tensions

Seven personal tensions critical to recovery were identified: 1) psychotic symptoms; 2) behavioral problems; 3) cognitive impairments; 4) emotional distress; 5) lack of motivation; 6) treatment-refractory illness; and 7) side-effects of medications.

Three consumer participants recalled their in-patient experiences while in crisis. One shared:

I was very mentally sick and very distraught and, well ... I was a basket case and totally emotionally distraught ... that's how far the drugs have gotten to me, I guess to the point where I just want to die. I wanted somebody to kill me or I felt like – very suicidal. (#5)

Another one said:

There's other patients that are mentally really incapable of doing much ... they're really ... incapacity ... they're slow, they have a hard time speaking ... some of them are even worse than that. Some of them are ... I don't know how to say, they're just mentally very, very incapable of much high thought of consecutive thinking. (#6)

This high level of acuity may affect patients' functional capacity and challenge providers' ability to promote recovery. Cairns et al. found that 43.8% of in-patients lacked the capacity to make proper treatment decisions (Cairns, et al., 2005). Providers have to pay greater attention to safety issues in response to patients' mental instability. Patients who present with behavioral problems such as aggression and intimidation, and risky or self-harmful behaviors are particularly challenging.

In addition, patients who present with motivational problems are difficult. Hughes in 2007 stated that:

It is frustrating to spend a couple of hours preparing and gathering equipment for one of my groups ... to find that only one client is willing to attend or that one or two are so disturbed in their mental states that they disrupt the group for others and nothing useful can be achieved. (p. 173)

The challenges and skills required to actively engage patients in meaningful activities when they are in an acute distressed status or when they are faced with negative symptoms or lack of motivation can be a source of frustration for in-patient providers.

The issue of side effects of medications is also a dilemma. All participants agreed that taking medication regularly is a significant way to recover. However, the consumer participants thought that, at times, experiencing the side effects was worse than living with psychosis of the illness. As a provider participant said, “most of them suffered from the side effects of the medications. That’s why they say no to medication.” Patients have limited access to alternative source of information and support regarding the role of medication in their recovery.

### 3. Providers’ own tensions

Six tensions associated with providers were identified: 1) lack of recovery competencies; 2) inability to transfer recovery knowledge to practice; 3) pressure, tension, and frustration associated with patients’ health conditions, as well as apparent conflicts between human rights and some interventions; 4) lack of motivation to change; 5) lack of support from colleagues; and 6) negative beliefs toward patients with serious mental illnesses.

There was a general agreement that many in-patient providers do not have the level of competencies required to provide recovery-oriented services. Beliefs and attitudes are the first concern. Because the medical model is a pervasive framework for solving in-patient problems, many providers place great

importance on medication. For example, provider participant #9 spent one third of the interview time talking about medication:

This field of the medication is new...and you know this hospital made a very good objective research of the medication and then it was found out that the medication that they need is, I mean, antipsychotic, it's much less than what they get. (#9)

However, medication is only one potential recovery support, among many. A provider participant expressed a desire for increased knowledge and skills for different therapeutic strategies because providers are not well equipped with alternative means of intervention.

All consumer and family participants were concerned about providers' attitudes. They placed a high value on providers who were approachable, sympathetic, who spent time with them and responded to them, and who appeared enthusiastic toward their role as a helper. Conversely, providers who did not show a respectful attitude made them feel inferior. A consumer participant found that his dignity was injured when he was "talked down to" or spoken to "like a child" by providers. Another consumer participant also expressed the same feeling:

Like some of them would just speak to you in a degrading manner. They would just like, you know, I'm sitting there ... I know I am sick or whatever but ... I still know what's going on I got.... You don't have to talk to me like I'm an idiot. (#6)

Family members reported similar experiences of being disrespected:

They [providers] stayed in their office and if -- if I wanted to go and speak to them about my daughter, I kind of have to go and stand at the door and wait until one of them looked up, you know, and paid attention to you, there was a very, very, very uncomfortable feeling. (#13)

Families felt slighted and disempowered when providers talked to them without standing up and going out of the station. The body language created a hierarchical obstacle.

Providers with respectful attitudes and behaviors were appreciated: "There's a group of [providers] that are genuine, sincere, they actually care about each and individual patient, respecting the individual

rights of all of them and not being favoritism to one and two” (#5). Being treated with respect, dignity, and sincerity is a major concern for consumers and families. They expected that providers should be “really nice and caring”, “talk to me normally”, and “try to help me” (#6). Four qualitative studies conducted in Canada, Scotland, Sweden, and USA also reveal the same expectations that patients want providers to be warm, supportive, listening, sensitive, helpful, flexible, and respectful, as well as communicate clearly, validate them, and understand them (Forchuk & Reynolds, 2001; Johansson & Eklund, 2003; Thomas, Shattell, & Martin, 2002).

The second provider level tension is limitations in transferring recovery knowledge to practice. Some providers expressed that they have an adequate knowledge of recovery, but did not comprehensively understand related concepts. They also expressed difficulty with knowing how to use the knowledge or how this knowledge should inform the way they do their job: “This is the knowledge, but in the practice, this knowledge is not transferred to the practice” (#9). An educator participant noted providers’ confusion around practical application of recovery:

There are some people that kind of sit on another end of a continuum that say, recovery is just about letting people do whatever they want. Because that[recovery] is supporting client choice, so that’s kind of on the end of neglect. There are other people that say, you know I really want to support somebody’s recovery, but I don’t want it to be stressful for them, so I’m going to make the situation in a way that they have to choose what I would like them to choose. So there certainly is challenge because people don’t understand, they see the concept but don’t understand what that means on a day-to-day basis, so it’s the practical application that’s really challenging for people. (#2)

The third provider level tension is providers’ feelings of pressure, tension, and frustration as a result of the health condition experienced by patients. In Table 3-3, twelve articles discuss this phenomenon as a barrier to quality services. The unpredictability and uncertain nature of the in-patient context is a source of pressure. Providers have the responsibility to closely supervise patients. They must be sensitive and vigilant, prepared to respond to the unexpected act at all times (Cleary, 2004; Hummelvoll & Severinsson,

2001; Johansson, Skärsäter, & Danielson, 2006). Frustration can result from patients' readmission, which seems to imply both patients' and providers' failure. Providers also experience a sense of conflict between human rights and therapeutic interventions. A feeling of inconsistency between the obligation of maintaining the stability of the ward and patients' safety and human rights always exists. The two nursing participants especially stressed this issue. As provider participant #9 stated:

Our job is going to be only giving cigarettes and getting cigarettes. This is, searching, searching clients --- when they come and then other times it's inhuman for them that it affected their dignity. But for the safety of the unit, we have to do that.

Provider participant #4 mentioned the dilemma faced by providers when patients make a choice which they perceive would not lead to a recovery-oriented outcome. He stated an example:

If the clients want to stay in bed, that's their prerogative. If they don't want to, you know, we would ask the clients to make your beds, no, I am not making my bed.... Staff weren't strict but there were some things that the clients had to do. You know, personal care ... when you look back that's part of recovery that you need to be this way. You just can't go out in public if you want to go for job interviews, that you're going to be unkempt looking.

Judging what is in the best interests of patients is a challenge for providers. Therefore, finding the balance between patients' rights and their benefits when they are in a crisis or acute illness is imperative in the inpatient context.

The sources of tensions also come from providers' feelings of being inadequately protected from exposure to a threatening environment. The potential violent responses from patients are the most direct source of feeling threatened. Another example is smoking. Provider participant # 9 articulated what she believed many of her colleagues felt: "Staff has to go smoking with them[patients]. And then a staff doesn't want to get a second hand smoke.... we cannot leave the patient. The patient may run away.... They feel good when they smoke ... but for a staff to [feel] sacrificed" (#9).

Provider participant #2 thought that, compared to other disciplines, nursing staff are more likely to experience these tensions and conflicts because of the characteristics of nursing duty. Eight studies in the literature review indicate in-patient nurses' experience of these tensions and pressures. These day-to-day pressures can lead providers to employ self-protective defences. Goodwin and Gore (2000) in their study found that nurses showed anti-task behaviors such as reduced contact time with patients and limited their emotional engagement as a defensive structure to protect them from anxieties. Duggin also shared his experience as an in-patient psychiatrist. After fighting with the old rules and feeling exhausted and overwhelmed, he "took the easy option, started following the rules ... withdrew into a protective shell" (Duggins, 2007, p. 119). Too much tension may cause providers to burn out. A family participant depicted the consequence of staff burn out in this way: "the burn out was, the staff that are just processing pills to keep them quiet, to keep them less of a bother" (#15).

The fourth provider level tension identified is the lack of motivation to change. As the educator participant #2 said, "the culture is really a culture of maintenance." Some providers, especially those who have worked in the in-patient field for a long period of time, just want everything to be done as usual. Changes sometimes mean disruption of their usual routine. Changes bring with them a feeling of insecurity, too. Smith and Bartholomew discussed how staff attitudes that tend to resist changes are challenges to how a recovery model can be implemented in the hospital context (Smith & Bartholomew, 2006).

The fifth tension for providers is the lack of colleague support and effective team work to facilitate recovery. Four provider participants pointed out this phenomenon. A provider participant said that she encountered some cynicism in the ward when she wanted to plan recovery-oriented services:

When I am trying to work with them[patients] and always trying to plan around discharge, there is a lot of cynicism because they have been in hospital for so long or because the patient has already been out in the community a couple of times, and it doesn't work.... So there seems to be a bit of a clash, not everybody buying into it. (#3)

Providers who felt really motivated to change could experience pressure by other colleagues to maintain the status quo. As the educator participant said:

The challenge is that not everybody has all of these skills. And some people don't support each other in them. So, people may be very motivated to change or to engage in some of these knowledge skills or behaviors, but then other people will make it difficult for them to do that, and be negative about it. So it makes it hard for them to have that continuity. (#2)

In-patient providers from different disciplines commonly have different goals and priorities in practice. They don't share a common identity, especially in terms of the subject of recovery. Incomplete, confused, or inadequate communication still exists among providers, which may be barriers to interdisciplinary work. Compared with the community settings, two provider participants thought that providers do not work as collaboratively in the institution.

The final provider level tension is providers' negative beliefs toward patients with serious mental illnesses. Providers were described as stigmatizers and feeling like they have to be "fixers". They have a tendency as professionals to act as problem solvers and dominate the decision making process. A provider participant reflected: "There is a problem, I have to look like I am competent, so therefore I am going to fix it, make it better, but they [patients] do not even want you to do it" (#3). In-patient providers were characterized as prone to perceive patients as incapable because the patients they meet are often in a crisis or persistent health condition. Presuming that patients might not be able to make proper judgements could lead to unintentional discrimination which results in less opportunity and autonomy for patients. Providers were also perceived as apt to associate the person with the illness, without understanding that some behaviors are by-products of the illness and do not epitomize the person. These stigmas might exist every day but providers might not be aware of them.



### 3.4.1.2 Practice and actions

Resulting from the aforementioned three levels of tensions is an in-patient practice dominated by a medical model of care, risk control, and a custodial framework. These three approaches to service delivery contribute to the in-patients' experience of segregation and restriction and also reinforce their passivity. Limited choices and constrained communication with providers are related social relations experienced in this context.

#### 1. The medical model, risk control, and custodial framework

The demand on treatment effectiveness especially in the acute psychiatric ward promotes the application of the medical model (Hummelvoll & Severinsson, 2001). The medical model views disability as patients' personal deficits requiring professional solutions. Services applying this model in mental health are directed towards the use of treatment in the form of medications that are expected to reduce most symptoms of mental illness. Consequently, "absence of symptoms" and "having good medication compliance" become perceived as two necessary indicators of recovery. For in-patient providers, practice is primarily guided by the medical model, overshadowing consideration of alternative treatment choices. As a family participant noted, "There was no kind of group therapy or anything like that. ...yes, it was just medication ... no talk therapy, nothing" (#13). In the interviews, all provider participants agreed that the medical model is extremely prominent in inpatient settings. For example, a provider participant expressed:

Now we have a report every morning and it's always about – most of the times, it's about medications ... so many acted out yesterday, like, they got a PRN or ... there could be a whole bunch of other things going on for that person and it's not, but it is very -- it's still very medical model. (#3)

Because of the application of the medical model, there are also few opportunities for patients to be involved in treatment decisions. As educator participant #2 stated, “I think that right now they’re very test-oriented and very medication-oriented.... There isn’t that environment of people feeling that their goals and needs are being encouraged, it’s more about the process and the routines, and about medication delivery.” She also noted that patients are often seen as an illness instead of a whole person:

If people don’t want to take medication or question taking medication, then that’s seen as being negative and people are often penalized for that. All of their behavior is attributed to whether or not they’re taking their medication or not taking their medication, and there’s no understanding of them as an individual and not as an illness. (Educator participant #2)

The medical model also implies a “problem-focused” philosophy under which the role of treatment teams is to identify patients’ medical problems and skill deficits. Interventions are designed to remediate patient deficits without routinely attending to building on the strengths demonstrated by patients (Smith & Bartholomew, 2006). Provider participant #1 talked about his team meeting:

Even the way that we typically chat or report, it’s usually problem-based. And so, if we go over what happened in a day ... a [provider] might describe, oh this person hit somebody and this and that ... and then the next person if nothing happened, they would say they are fine and they just move on to the next ... instead of saying, they went to the center and helped with the dishes and also demonstrated a new social skill that they learned. There isn’t that type of thing, it’s more so, what’s wrong with people. (#1)

Provider participants all expressed the importance of the strengths-based practice, but stated, in the real world, “We do look at strengths but not as much as the problems” (#3).

The second approach is risk control. There is a high expectation that providers can manage all possible risks to ensure patient safety. This demand is referred to as “professional responsibility” and creates a situation where if an accident or dangerous event did happen, the provider would be blamed accordingly. As a result, inpatient services have given primacy to avoiding harmful risk. Since providers are in a sensitized state and vigilant to possible danger, compulsory intervention to reduce risk is

common. The control and avoidance of risks consumes a great proportion of providers' energy. However, some risk avoidance interventions restrict in-patients' opportunities to access resources. A consumer participant illustrated:

They had a pool table in there but they wouldn't let us -- they wouldn't give us the ball, like they wouldn't let us use it ... because I guess maybe they were scared of throwing the ball, some, you know, you could use them as weapons I guess the pool balls or throw them ... so anyway they have this pool table in there, which never, we never used. (consumer participant #6)

Restricting the activity participation of patients in order to protect them from any potential risk also limits the opportunity for learning and risk self-management. This restriction unintentionally fosters a cycle of disengagement and reduces the extent to which patients develop skills of taking responsibility, a critical element of recovery. An educator participant also pointed out a key element of risk taking: Do providers have enough competencies and autonomy to support positive risk-taking? She said:

Do the staff feel that they can take risks? So being in a big in-patient hospital, there is a lot of risk of emergency, so people do not take a risk. You can't be client-centered and have people do things, if everybody is so afraid to take a risk. (#10)

The third approach is the custodial framework. In-patient providers use various control strategies to manage the settings. For example, they searched through patients' belongings to prevent potential destructive events. Such actions are justified as protection of patients. Similarly, every patient had to wait until providers were available in order to obtain the permission required to do things such as having a visitor, taking a shower, or leaving the wards. The three consumer participants complained about being confined to daily activities, although at the same time, they knew it was necessary for security reasons. As consumer participant #5 described:

They have a yard there. When you go out to yard, and it's a fenced in yard ... If you're coming in, they have to -- there're no monitors. They have to [use]... metal detector and then they search you in your pockets and then let you go back in the ward. But you have to do that to get inside.... if you come in on a shift change ... a [provider] has said, "Who's coming in? How dare they come in while we're having shift change?"

The consumer participants expressed strong feelings about being under close surveillance. Indeed, the custodial framework ensures that providers were in control of everything patients did. Johansson, Skärsäter and Danielson in their study concluded that the in-patient environment is overshadowed by control (Johansson, Skärsäter, & Danielson, 2006). An educator participant noticed that, “the routines are around eating, bathing, and getting those sorts of things done ‘for’ people” (#2). As a result of providers managing the lives of patients without sharing responsibility, patients may lose basic skills with prolonged constraint and become dependent on providers. This tends to hinder rather than facilitate recovery and perpetuate passivity.

## 2. Limited engagement

Limited engagement, which includes segregation, restriction, limited choices, and constrained communication, summarizes the practices embedded in the medical model and custodial framework.

In the interviews, a strong sense of segregation and restriction emerged around patients being unable to get personal belongings, visit friends or do activities, and be involved in their treatment planning. There were mixed opinions on the issues of activity participation. One family and three consumer participants complained about the lack of activities. They expressed a need for more activities and stimulation. Inactivity was described as a contributing factor to depression and disorientation. For example, consumer participant #6 remarked: “So you got to stimulate the mind, stimulate the body, stimulate the soul ... you can’t just pump pills ... you can’t just feed them pills and expect them to get better.” Consumer participants expressed their desire for more recreational and training opportunities in the in-patient setting. However, a number of provider participants mentioned their efforts to engage patients with activities. Both patients and providers have an overarching desire for activity participation.

Providers require more open dialogue with patients and ongoing reconciliation of patients' experiences and expectation with the environmental restrictions in order to engage patients within the in-patient context.

The in-patient setting is described as having no protected channels through which patients can articulate their voices. An educator participant conveyed patients' perception:

People are concerned that if they voice concerns about the care that they're getting, that they're going to get more restrictions, they can have their activity levels taken away, they can be put in seclusion. So there's a great deal of loss of control and autonomy. (#2)

The interview data suggested that the therapeutic alliance is compromised by the lack of mutual communication. A family participant reported being excluded from her daughter's treatment planning and described her daughter's experience of restricted activity participation: "She didn't like being there because there was no -- there was nothing really offered to them" (#13). In the literature patients have reported their dissatisfaction with exclusion from treatment planning, lack of family involvement, and lack of education (Howard, El-Mallakh, Rayens, & Clark, 2003). The literature also indicates patients' and family members' experience of lack of information and ineffective communication with providers (Gilburt, Rose, & Slade, 2008; Moyle, 2003; Varley, 2007). Similarly, a strong desire for patient engagement in their own care, therapeutic activities, and service design was found in a survey study by Brimblecombe and colleagues (Brimblecombe, Tingle, & Murrells, 2007). The communication between patients, families, and providers is problematic from the perspective of recovery. The patients and families interviewees wanted to know the process of treatment decision and planning, but expressed that this information was not explicitly delivered:

They don't tell you your planning. They tell you, you are doing okay, so now we are going to give you a 10-minute smoking pass. So then you go for a smoking pass. Okay, now we are going to give you a weekend pass. So you go for the weekend and come back and then they say okay, you know, as long as you continue to do well, I think you can get released in like another

week. And then they -- they do it that way. But they don't give you a treatment plan like at the start; they sort of see how you are doing" (#6)

Constrained communication can prevent patients from getting information and exercising choices.

The choice related to medication is an example. As provider participant #9 remarked, if a patient wanted to renounce medication,

The [name of a Board] decides either take it or not take it, nothing in between. Nothing in between. And that's what we said to them if they say that "we don't want medication". We put them in a condition that they failed... they come off the medication, they get worse, they go through withdrawal, they go through a very difficult time and then they may do lots of things and then their situation gets worse than before than when we put them. We say okay, you needed that and you have to take it"

This example implies that, there is constrained mutual communication and discussion of alternatives when patients make a choice not to take medication. In-patients are confined to make their own choices, or are given choices within a narrow range of restrictions predefined by providers.

Limited engagement, as discussed above, fosters a focus on patients' passivity rather than active participation, by conveying the message that patients are not capable. As provider participant #3 thought, "There is a real lack of engaging with patients beyond just the primary needs." Patients' dependence on providers is reinforced because their daily activities are scheduled and overseen. Patients do not have opportunities to practice. Patients' passivity was shown not only in the daily routines but also in recreational activities. Family participant #13 described her daughter's disappointment: "She wanted to try -- she said she tried to get some of the other patients involved in doing some exercises in their lounge, but nobody was really interested to doing that with her."

#### 3.4.1.3 Consequences

Hopelessness, powerlessness, and compromised relationships between patients and providers can be identified as clinical consequences resulting from the three levels of barriers that exist and the practice models that are applied in the current inpatient context.

## 1. Hopelessness

Recovery literature indicates that hope is central to recovery. Loss of hope can lead to giving up or withdrawal. For patients with mental illness, loss of hope may inhibit their positive outlook on the present and future. In addition, environmental factors, such as the boredom and dreariness characteristic of the inpatient setting and the unsupportive attitudes of people around them, have also been identified as hope destroying (Bopp, Ribble, Cassidy, & Markoff, 1996). As educator participant #2 mentioned:

I would agree that lots of people have lost hope. But it's really important that the people around them and the system hold on to that hope and set that as the standard instead of creating an environment of either taking care of people or sending people the message that, you know, now that you have schizophrenia, you're not going to be able to work. (#2)

Limited engagement can contribute to the sense of hopelessness. To avoid this consequence, in-patient services need to deliver in ways which foster hope and optimism. If the possibility of a positive future is rarely communicated by providers, it is easy for patients to believe that they will never recover. Without finding their personal meaning and value, patients will lose their expectations for the future (Slade, 2009).

Providers also experience feelings of hopelessness. If providers only see in-patients with severe personal barriers, such as psychiatric symptoms or distressed emotions, then the available evidence suggests to providers that serious mental illnesses are associated with poor prognoses and high levels of disablement (Slade, 2009). In the interview, provider participant #11 discussed this point: "if people [providers] who only see people [patients] when they're ill ... I think ... perhaps, [they are] less hopeful." He pointed out that a source of hopelessness was the use of the medical model: "part of what can happen

in the use of biomedical [model] ... is that [providers] lose hope. And they feel sad and disheartened.” He also concluded that, “so part of the important thing with hope is that the staff have to feel hopeful and the clients have to feel hopeful” (#11).

## 2. Powerlessness

All participants agreed that providers hold power and have the control in the in-patient setting, from personal care activities, to medications, to whatever happens in the ward. Five studies in the literature reviewed indicate that there is an obvious power difference between patients and providers (Cleary, 2003; Johansson, Skärsäter, & Danielson, 2006; Moyle, 2003; Oeye, Bjelland, Skorpen, & Anderssen, 2009; Robert, Hardacre, Locock, Bate, & Glasby, 2003). Consumer participant #7 described her negative experience of being coerced: “They put me in a locked room until I calmed down, or about to feel better. I don’t like it.” She thought she did not have enough power to express herself. Findings suggest that sometimes providers call an action “treatment”, but patients may experience it as coercion. Consumer participant # 6 felt uncomfortable that providers had the power to decide his discharge day while he was not offered any explanation. Providers seem to be the experts on making the best decisions for patients in terms of treatment goals and treatment choices. This underlying belief, that providers are the experts on making the best decisions for treatment goals and choices, characteristic of the medical model, may disregard personal experiences. On the other hand, a primary emphasis of recovery-oriented services is the “expertise-by-experience” of patients with mental illness. Only the person him or herself can define his or her best interests.

Another issue is the sharing of power. Providers can feel uncomfortable when sharing power with in-patients, because they worry that professional boundaries and authority may be undermined. As well, they do not have confidence in in-patients’ judgment. McCann, Baird, and Lu conducted a study exploring professionals’ attitude toward consumer participation. The result indicated that professionals supported



consumer participation, but showed disagreement in matters threatening to their professional authority such as consumer access to their medical files or involvement in staff education (McCann, Baird, & Lu, 2008).

All the barriers discussed in the previous section can contribute to less power sharing. For instance, in the in-patient context, the decision-making power is not shared, especially regarding the medications used and discharge planning. Providers are largely the decision makers; at the same time, responsibility for the consequences lies more with providers. A shift in power also means shifts in responsibility accompanied by changes in communication styles and structures, development of alternative treatment options and commitment to strengths based approaches.

### 3. Compromised relationships

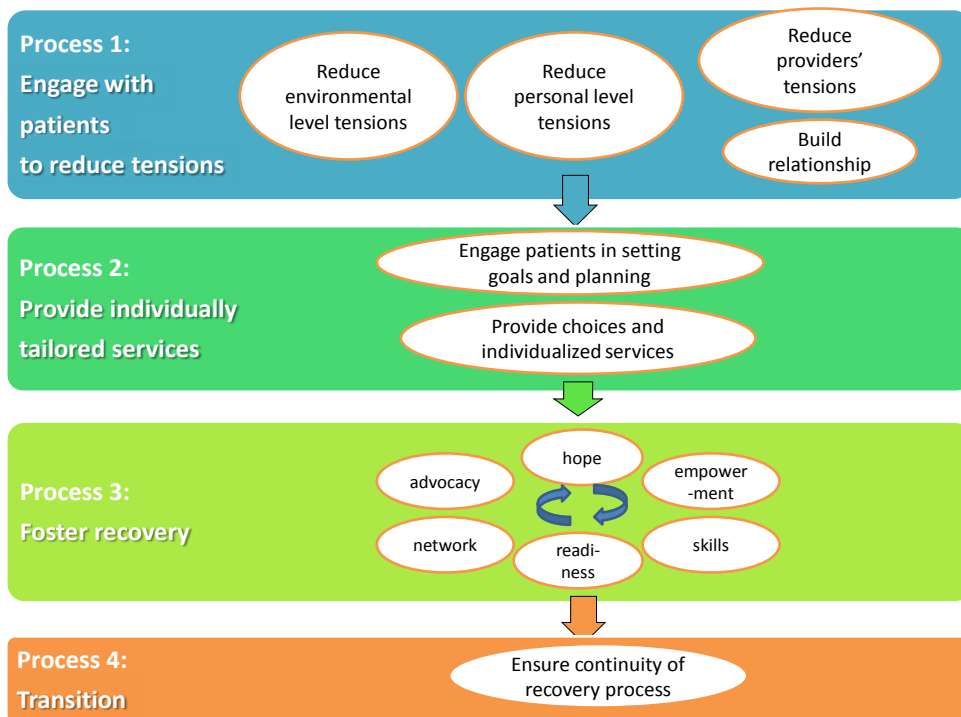
As a result of power differences and constrained communication, it is difficult for patients and providers to form collaborative or partnership relationships in the in-patient setting. In the interviews, the consumer participants were particularly concerned about relationships. Similarly, two studies in the literature review found that patients identified the relationship with providers as the core of their in-patient experience and as important to their recovery (Forchuk & Reynolds, 2001; Gilbert, Rose, & Slade, 2008). Patients expect to have a “good” relationship with providers. However, the actual experience fell far short of this ideal. As consumer participant #5 described, "It's like when you're in a bad relationship at home, like, when you have a poor parental---upbringing."

Educator participant #2 offered her observation: “they [providers] spend a great deal of time in the ... station away from the clients when they should be in the environment talking with clients, talking about what's going on with them and really working on developing the therapeutic relationship.” She thought that the challenges to developing strong therapeutic relationships include providers' lack of

knowledge as to the presentation of the illness, the interactions of the medication, and the way to support patients. In addition, the stress which created burnout symptoms in some providers could destroy relationships. When a therapeutic alliance based on mutual trust is not established, providers are not going to hear patients' voices. The emphasis on effectiveness under the medical model may direct providers' attention to only medications and symptom remission, rather than on what is really important for patients, such as a collaborative relationship to work together on creating solutions to problems.

### **3.4.2 The process framework to enable providers delivering recovery-oriented services**

The tension-practice-consequence model discussed in the previous section demonstrates a cycle in current in-patient practice, which is not actually a recovery-oriented service. To change the circumstances, a process framework to enable in-patient provider delivery of recovery-oriented services is proposed (see Figure 3-2). There are four processes in this enabling framework. The first process is engaging with patients to reduce the environmental, personal, and provider levels of tensions. The second process is providing individually tailored services, including engaging patients in setting recovery-oriented goals and planning and providing individualized services. The third process is fostering recovery, comprising hope instillation, empowerment, skill building, preparation for readiness, network building, and advocacy. Finally, the fourth process is providing transitional services to ensure continuity of the recovery process.



**Figure 3-2 The recovery enabling framework for in-patient providers**

1. Process One: Engage with patients to reduce tensions

Process One is engaging with patients to reduce tensions to recovery. The framework here highlights the importance of engagement. Engagement involves making contact with patients, attending to their needs, and providing a range of opportunities. Of particular importance in promoting engagement is: 1) provider awareness of, and sensitivity to, the very fine line between persuasion and coercion and 2) attention to the power differential between providers and patients and the factors which can undermine personal choice (Tendra & Davidson, 2006). For patients, engagement is not only a goal, but also a necessary process on the path to recovery (Firm, 2008). Reducing barriers to enabling recovery depends on collaborative partnerships between stakeholders. For the environmental level tensions, providers can

engage patients in creating an environment, in which patients feel safe, accepted, helped, and nurtured while also maintaining ordered in-patient settings. For instance, patients can be involved through formal and explicit mechanisms in designing the physical layout, setting commonly accepted ward rules, and identifying and securing resources. Patients may need providers' assistance in building positive relationships with others. This is also a way to stimulate patients' awareness of and involvement in the environment to enable them to take responsibility for their own lives. Moreover, family members want to be treated as resource people (Wallace, Robertson, Millar, & Frisch, 1999). They know the patient better than do providers and will likely be involved upon discharge. Involving families can assist providers in grasping patients' current status in the context of their whole life and provide more of the support that patients want.

Reducing personal level tensions depends on the integration of bio-psycho-social models of interventions. As discussed in the previous section, no one model can provide both in-depth and global satisfaction of patients' needs. A more comprehensive practice with the potential to address all aspects of a person's issues and promote recovery needs to incorporate a variety of models: 1) the biomedical model, which can help in reducing psychiatric symptoms and stabilizing emotion; 2) psychological models, such as cognitive therapy to change maladaptive behaviors and thoughts; 3) social models, such as supportive therapy to strengthen coping skills and diminish vulnerability; and 4) the social-political models of disability, which change environments to enable recovery. The final purpose is to engage patients in equipping themselves with knowledge and skills to manage their health and well-being in their preferred ways.

In terms of reducing providers' own tensions, attitudes and beliefs are the first concern, as they can have a fundamental effect on providers' behaviors. A respectful attitude includes valuing individual needs, privacy, confidentiality, dignity, voices, rights, pace, and choices. As well, providers must be

careful about unintentional stigmatizing language such as the use of a diagnosis-based label. Consumer participants thought that, even in a restricted environment, providers could at least “respond to” instead of “ignore” their individual needs. Providers should frequently self-reflect to ensure that their attitude, knowledge, and behaviors are recovery-oriented. They also need to actively convey these attitudes in the field.

Building relationships is embedded in the process of reducing tensions. A real partnership means working together and contributing equally in the process of service delivery. To achieve this status, providers have to recognize and take an honest look at the hierarchy of the power structure in the in-patient setting, especially the prominence of the assumption that the professional is the expert and knows best. For the power structure to be renegotiated, the nature of relationships becomes less prescriptive and more collaborative (Pennsylvania Department of Public Welfare, 2005). Providers can share their “traditional” power of making treatment decisions and control over services. They can also establish a mechanism for power sharing by building formal relations with peer-support organizations or introducing peer workers in the in-patient setting. The power sharing can promote the mutual empowerment and allow shared goals to be achieved. In the in-patient setting, complete power sharing is possible only when providers become practitioners who believe in and are knowledgeable of recovery, and who are able to self-reflect and encourage changes.

## 2. Process Two: Provide individually tailored services

In the interviews, both the family and consumer participants highlighted the significance of recognizing and responding to individual differences of each patient. One of the critical recovery values is being person-centered referring to services that focus on the individual first rather than focus on the person as his/her illness. This value provides a fundamental orientation for providers in practicing

recovery-oriented services. First, providers engage patients in setting their own recovery goals and planning, and help them work towards these goals. Some in-patients may be involuntary admitted to the hospital or in a crisis state. Providers have to recognize the need to develop and evaluate practices that engage patients even in this state. In a partnership relationship, providers and patients work as collaborators to develop patients' personal meanings and transfer those meanings into goals and action plans. During this process, patients need providers' support to identify their strengths and develop positive self-identity.

Second, the in-patient providers have to address the unique needs of patients and find the balance between respecting patients' choices and maintaining the ward structure. The traditional in-patient setting is largely directed by a control-oriented approach which focuses on safety and external control. Personal needs are not always taken into account. In contrast, the recovery framework is oriented to choice and self-control. Patients need to be supported in various choices even within a restricted environment. Hence, the providers' role is to find a balance between offering choices based on individual needs and maintaining ward structure through negotiation of positive risk taking with support. Positive risk-taking leads to personal growth and development (Slade, 2009) and can be supported through transparent communication. Patients can benefit from this learning process rather than from avoiding harmful risk.

### 3. Process Three: Foster recovery

Fostering the positive cycle of hope, empowerment, meaningful life, and personal growth is central to recovery. There are some strategies providers can use to facilitate recovery. The first one is hope instillation. Hope is an important element of and a starting point for patients' recovery. Patients with higher hope are more likely to be motivated to take personal responsibility and to cope with challenges in moving ahead in recovery. To instill hope, providers can convey belief in patients and envision future

lives for them even when they are hospitalized. The second strategy is facilitating empowerment. Empowerment is an interactive process to enable patients to be active participants in maintaining their own well-being and to take action to achieve influence over their environment (Wilson, 1996). In the in-patient setting, empowerment can be achieved through sharing information and power and improving communication. Encouraging patients to make decisions in discharge planning is an example to increase their feelings of self-worth and competency. The third strategy is building patients' strengths and skills. Helping patients find their strengths and acquire specific skills is a way to facilitate personal empowerment and also a step toward achieving personal goals. In the in-patient setting, providers can support the development of illness self-management, which aims to equip patients with skills and supports to control their illness and prevent symptomatic disturbances during critical stages of recovery (Lieberman, 2008). Illness self-management is consistent with the medical framework of the in-patient setting and perhaps more easily embedded in routine practice. Other skills patients need include coping skills, living skills, social skills, vocational skills, and so on. To link between the in-patient environment and community skills, providers require an understanding of patients' lives in the community and adapt the in-patient setting to create an environment where these skills will be developed and used. These skills can support patients to move forward to a more functional life and live in a more meaningful and satisfying way.

The fourth strategy is building patients' personal networks. While the in-patient setting is separated from the community, the in-patient setting may be constructed to provide opportunities for patients to have contact with the community. Providers have to help patients identify their valued social roles as well as build and maintain more connections, relationships, and resources. Building and maintaining relationships with partners, families, friends, employers, neighbors, mental health providers, other service

users, and social resources can bring them a sense of belonging, develop positive self-identity, and encourage future orientation.

The fifth strategy is preparing patients' readiness for the next steps of the recovery processes. Readiness refers to patients' desire or motivation to act to pursue their goals. Factors impeding patients' readiness for recovery may include repeated failures, lack of skills and knowledge, inadequate supports, or inappropriate goal setting (Pratt, Gill, Barrett, & Roberts, 2007). For example, some patients with long-term psychiatric conditions have been in hospital for lengthy periods of time. They may become habituated to the role of "psychiatric patient" and have low motivation to change. They may also lack the confidence necessary to access the outside world. The issue of how prepared patients are to re-enter the community is a critical element in helping them succeed in their attempts to pursue personal goals.

The final strategy is to help patients to know their rights and to self-advocate. Self-advocacy involves patients defending their personal rights or banding together to support a common issue (Pratt, Gill, Barrett, & Roberts, 2007). In in-patient settings, patients can be encouraged to become involved in the ward administrative procedures, articulate their voices, and monitor the results of their proposals. To further solve their problems and advocate for their rights in the community, patients need to practice communication skills with third parties such as landlords or social agencies. Providers can introduce patients to resources such as self-help initiatives and consumer-run organizations. Involving peer-provided services in in-patient settings is an effective way to empower patients and help them envision a way to not only strengthen their own personal support systems, but also help other peers. Together they can create a stronger mental health system by advocating for additional services, rights, and resources.

These six strategies are inter-related. Patients' recovery is further enhanced through fostering a positive cycle of hope, empowerment, skill building, network building, readiness, and advocacy. This is



not a linear process. Although some in-patients' hospital stay is brief, providers can still play the role of facilitator and be conducive to patients' recovery.

#### 4. Process Four: Ensure continuity of recovery process

Providers in the in-patient setting need to consider, as part of the recovery process, how to help patients solve the problems they may encounter upon discharge. These problems can include, for example, problems of finances, housing, relationships, employment, education and resources. Patients and families need ongoing support after leaving the hospital. As a family participant complained, "Once the patient leaves the hospital environment, that support is removed ... and very often, they [patients] can't adapt to the life and challenges being outside the hospital ... because inside is very nurturing" (#15). Therefore, providers have to ensure the transition process from hospital to community is smooth and that recovery-oriented mental health services are delivered in an uninterrupted flow over time. For example, in-patient providers can strengthen partnerships and information exchange with local community services to reduce patients' experience of fragmented care, including structuring the in-patient experience so they have opportunity to meet community supports. On returning to the community, patients may need a community team helping with illness management and re-establishing them in the community, a vocational program or assisting with obtaining employment, or a peer organization for ongoing support. Integration of community resources and connection to patients and families with discharge from in-patient settings is essential to assist patients on their way to recovery.

#### **3.4.3 Key challenges and related competencies in delivering recovery-oriented services**

Recovery is sometimes considered an idealistic philosophy that is not practical, especially in the in-patient context which is characterized by the traditional features of the medical model, restriction, and

segregation. Some recovery values directly challenge medical oriented assumptions. For instance, self-determination will be compromised for patients who are involuntarily admitted to the hospital. Thus, many challenges exist when in-patient providers try to provide recovery-oriented services. This section identifies the challenges that emerged from the interview data and proposes competencies to address those challenges. These competencies provide a pragmatic framework to enable in-patient providers to deliver recovery-oriented services. Ensuring that recovery-oriented services are practical and useful within the current in-patient structure is a primary consideration.

### 3.4.3.1 Competencies related to reducing environmental level tensions

**Table 3-4 Challenge 1 and suggested competencies**

<b>Process 1: Engage with patients to reduce tensions</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>1. Engage with patients in creating an environment in which they feel safe, accepted, helped, and nurtured while also maintaining an ordered in-patient setting</i>	
<p><b>Challenge 1. The environmental level tensions</b></p> <p><i>Critical tension: Patients perceive the in-patient environment as non-humanistic, inflexible, unsafe, and lacking in stimulation.</i></p> <ul style="list-style-type: none"> <li>a. non humanistic physical environment</li> <li>b. inflexible ward routines</li> <li>c. unsafe atmosphere</li> <li>d. lack of resources</li> <li>e. hierarchical power structure</li> <li>f. institutionalization</li> </ul>	<p><b>1. Competencies to reduce environmental tensions</b></p> <ul style="list-style-type: none"> <li>a. create a warm and vital physical environment</li> <li>b. create an environment in which patients' privacy is respected</li> <li>c. develop a flexible ward schedule and integrate balanced routine of self-care, productivity, and leisure activities.</li> <li>d. create a safe, supportive, and accepting atmosphere</li> <li>e. provide initial orientation of all in-patient services to patients and families</li> <li>f. involve community resources and support</li> <li>g. ensure that patients have access to updated and good quality of activity resources</li> <li>h. be willing to share information, knowledge, responsibility, and power with patients and significant others</li> <li>i. control the environmental stimulation which is suitable for patients' current status</li> </ul>

The first critical tension (Table 3-4) is that patients perceive the in-patient environment as non-humanistic, inflexible, unsafe, and lacking in stimulation. In order to reduce those environmental tensions, providers should be able to engage patients in creating an environment, in which they feel safe, accepted, helped, and nurtured while also maintaining an ordered in-patient setting. If providers are open to patient involvement, more opportunities could be created.

Providing an initial orientation of all services to patients and families is the first step in reducing patients' and family members' fear and anxiety and offering them a feeling of security and acceptance (Fagin, 2007). Patients can take an active part in determining the design and decoration of the environment. Introducing living things such as plants into the ward can bring a sense of growth and instill hope, in addition to providing opportunities to engage in daily routines typical of community life.

The environmental design should enhance patients' sense of privacy and dignity, for example, by offering a private space for family or friend visits. When providers need to check patients' personal belongings, they should be respectful in their manner, explicating the rules underlying such procedures and treating personal items with care. For some patients, the in-patient environment can be hostile and overwhelm personal coping resources. Provider competencies include recognizing the environmental impact and not assuming patients' behaviors are the results of their illness alone. Patients need a safe and supportive atmosphere characterized by freedom to express ideas and maintain a sense of justice. Provider competencies include consideration of all these factors in the environmental design.

A key competency involves providers finding ways to create more flexible routines under conditions of restricted time and resources. The basic principle must be to respect patients' human rights and satisfy their personal needs, while at the same time maintaining the necessary structure of the in-patient setting. Engaging in-patients in forums that engage them in learning about, and contributing to the unit structure can facilitate a climate of collaboration and mutual understanding through shared control wherever this is

possible. Another competency for providers is to integrate a balanced routine of self-care, productivity, and leisure activities. Passive television watching and naps in response to limited opportunities are not conducive to recovery and well-being.

Involvement of community resources and support can offer patients more opportunities to access the outside world and provide them with more stimulation and connection. The introduction of community volunteers is the best example. A competent provider can utilize these resources to benefit patients and ensure that patients have access to good quality resources. As a result, recovery can be promoted through environmental modifications and supports.

With regards to decreasing institutionalization, a competent provider has to control environmental stimulation to ensure it is suitable for patients' current status. Some in-patients cannot bear too much stimulus while other patients may need more activities to trigger their active engagement. For longer stay patients, introducing new activities to connect them with the community is a way to reduce the effect of institutionalization.

### 3.4.3.2 Competencies related to reducing personal level tensions

**Table 3-5 Challenge 2 and suggested competencies**

<b>Process 1: Engage with patients to reduce tensions</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>2. Engage patients in equipping themselves with knowledge and skills to manage their health and well-being in their preferred ways</i>	
<p><b>Challenge 2. The personal level tensions</b></p> <p><i>Critical tension: Patients may be experiencing acute illness or other experiences of distress which prevents them from engaging in recovery planning.</i></p> <ul style="list-style-type: none"> <li>a. psychotic symptoms</li> <li>b. behavioral problems (intimidating, risky, or self-harmful behaviors)</li> <li>c. cognitive impairments</li> <li>d. emotional distress</li> <li>e. lack of motivation</li> <li>f. treatment-refractory illness</li> <li>g. side-effects of the medications</li> </ul>	<p><b>2. Competencies to reduce patients' inherent tensions</b></p> <ul style="list-style-type: none"> <li>a. integrate bio-psycho-social models of interventions through implementing evidence-based and best practices, such as psycho-pharmacotherapy, cognitive therapy, CBT, supportive therapy, reinforcement therapy, temporary controlling therapy, family psychoeducation, group therapy, activity health intervention ...</li> <li>b. apply motivational enhancement strategies</li> <li>c. understand patients and their stages of recovery</li> <li>d. provide patients with information</li> </ul>

The second critical tension providers face is that in-patients are often experiencing acute illness or other experiences of distress which prevents them from engaging in recovery planning (Table 3-5). In the in-patient setting, not only active and disturbing symptoms of mental illness but also symptoms resulting from “institutionalization syndrome”, such as extreme dependence and passivity, can interfere with patients’ participation. Practices such as seclusion and restraint have historically been used for managing patient’s behaviors and for providers’ and other patients’ safety. Patients with low motivation may easily be neglected and have little chance to access resources in a custodial maintenance environment. Moreover, patients and families often note that they are ignorant of the information they need. In these cases, fundamental personal barriers are not reduced and the processes of recovery are undermined. In a

recovery-oriented service, providers should be able to engage patients in equipping themselves with knowledge and skills to manage their health and well-being in their preferred ways. They also need to provide patients with information about their illness and empower them in the learning process of illness self-management. Delivering these recovery-enabling practices depends on providers' understanding of patients and their stages of recovery and matching evidence-informed practices to meet personal level tensions.

The application of motivational enhancement strategies is a specific approach to activate patients who are not ready to change. Expressing empathy through the use of reflective listening is fundamental to initially engaging and communicating with patients (McCracken & Corrigan, 2008). To reduce personal level tensions, providers need to know a variety of treatment choices and alternative models of care beyond medications. A competent provider should be able to integrate bio-psycho-social models of interventions through implementing evidence-based and best practices, such as psycho-pharmacotherapy, cognitive therapy, cognitive-behavior therapy, supportive therapy, reinforcement therapy, temporary controlling therapy, family psychoeducation, group therapy, activity health intervention, and so on. A working knowledge of a range of interventions from different perspectives can address the multi-dimensional process of recovery. Introducing interventions and approaches within a relationship that seeks to develop and support collaboration and autonomy is a key competency.

### 3.4.3.3 Competencies related to reducing provider level tensions

**Table 3-6 Challenge 3 and suggested competencies**

<b>Process 1: Engage patients to reduce tensions</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>3. Become a practitioner who believes in and is knowledgeable of recovery, and who is able to self-reflect and encourage changes</i>	
<p><b>Challenge 3. Providers' own tensions</b></p> <p><i>Critical tension: Providers do not demonstrate recovery attitudes, knowledge, skills, and behaviors in their daily practice.</i></p> <ul style="list-style-type: none"> <li>a. lack of recovery competencies (belief in medical model, non recovery-oriented attitude...)</li> <li>b. inability to transfer recovery knowledge to practice</li> <li>c. feelings of pressure, tension, and frustration as a result of patients' conditions, as well as apparent conflicts between human rights and some interventions</li> <li>d. lack of motivation to change</li> <li>e. lack of colleague support</li> <li>f. providers' own beliefs toward patients with serious mental illness</li> </ul>	<p><b>3. Competencies to reduce providers' own tensions</b></p> <ul style="list-style-type: none"> <li>a. demonstrate recovery attitudes/beliefs (respect, empathy, inclusion, client-centeredness, focus on strengths...)</li> <li>b. demonstrate a holistic understanding of recovery knowledge: dimensions and stages of recovery, the meaning of recovery for all stakeholders, models of services delivery, discrimination and stigma issues, transfer of knowledge to practice</li> <li>c. be able to build collaborative and trustful relationships with patients and their significant others</li> <li>d. practice in the role of recovery guide, coach, mentor, and facilitator</li> <li>e. be able to self-reflect</li> <li>f. use understandable, respectful, and empowering verbal and body language</li> <li>g. advocate recovery within the in-patient teams</li> <li>h. be able to resolve conflicts or issues raised in recovery-oriented services, and facilitate interdisciplinary communication</li> <li>i. convey attitude of active respect and dignity for patients' rights and freedoms in all environments</li> </ul>

The third critical tension providers may experience is a lack of recovery attitudes, knowledge, skills, and behaviors in their daily practice (Table 3-6). As a result, feelings of pressure, tension, and frustration may exist. To become a competent provider in delivering recovery-oriented services, one must believe in and be knowledgeable of recovery. An effective provider is required to demonstrate recovery attitudes such as respect, optimism, empathy, inclusion, client-centeredness, and recognition of patients' strengths.

Another basic requirement is a holistic understanding of recovery knowledge, including dimensions and stages of recovery, the meaning of recovery for all stakeholders, different models of service delivery, and social issues related to serious mental illness. Providers must be able to transfer this knowledge into daily routines demanding the ability to understand how to integrate recovery practices within the specific experience of the in-patient context.

Providers also need to be skilled at communication in order to build collaborative and trustful relationships with patients and their significant others. The use of understandable, respectful, and empowering verbal and body language can enable their participation. An important issue for in-patient providers is to reconcile the negative impact of the professional hierarchy on recovery by being sensitive to expressions of power and being willing to share information, knowledge, responsibility, and power with patients and family. The provider identity in the recovery relationship reflects power sharing by delivering practices consistent with being a recovery guide, coach, mentor, and facilitator, rather than a caretaker. Frequent self-reflection is a critical competency to help providers check their own behaviors to avoid unintentional prejudice, discrimination and expressions of power.

Given the many tensions to the delivery of recovery oriented services in the in-patient environment, the conflicts and issues that emerge need to be openly discussed, debated, and resolved. A competent provider must be willing and able to identify and talk about these issues with other team members (Pringle & Brittle, 2008). Also, effective communication among providers is particularly important for effective services because of the diverse nature of mental health disciplines. To recognize that no one profession can provide all required services is a key to effective collaboration. The diverse views should be accommodated to achieve a commonly identified goal. In this way, competencies related to interprofessional practice are integral to recovery. A competent provider should also be capable of conveying an attitude of active respect and dignity for patients' rights and freedoms in all environments.



3.4.3.4 Competencies related to setting goals and planning and providing individually tailored services

**Table 3-7 Challenge 4 and suggested competencies**

<b>Process 2: Provide individually tailored services</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>4. Engage patients as collaborators in setting their own goals and planning, and help them work toward these goals</i>	
<p><b>Challenge 4. Setting goals and planning and providing individually tailored services</b></p> <p><i>Critical tension: Intervention and decision making are based on the medical model. Patients are not empowered to take responsibility.</i></p> <ul style="list-style-type: none"> <li>a. significant others don't support recovery; stakeholders' goals are different</li> <li>b. patients insist on goals that appear unrealistic /unfeasible</li> <li>c. patients depend on hospital care and don't appear to move forward</li> <li>d. time challenge 1- patients' high turnovers. Acute in-patients do not have enough time to implement recovery planning</li> <li>e. time challenge 2- practitioners' time constraints. Practitioners do not have enough time to offer time-consuming services or cannot satisfy different patients' needs at the same time</li> </ul>	<p><b>4. Competencies to set goals and planning with patients and provide individually tailored services</b></p> <ul style="list-style-type: none"> <li>a. demonstrate a holistic understanding of patients by assessing people and their context objectively</li> <li>c. interpret perceived deficits within a strengths and resiliencies framework</li> <li>d. be able to effectively communicate to patients and their significant others</li> <li>e. incorporate all stakeholders' goals and involve them in decision making</li> <li>f. educate significant others and involve them in in-patient interventions and approaches</li> <li>g. help patients reframe situations and plan concrete next steps, along with specific timelines</li> <li>h. set individual recovery outcome indicators</li> <li>i. prioritize patients' goals and needs</li> <li>j. develop and lead groups which are organized to meet individualized goals for each patient</li> </ul>

The fourth critical tension (Table 3-7) is that current in-patient practice is based on the medical model in which interventions and decision making are dominated by providers. Recovery competencies in the in-patient setting require the capacity to move beyond the illness-focused perspective of the medical model, to develop and support patient responsibility, acknowledge and integrate patients' treatment preferences, and involve patients and other stakeholders in decision making related to personal mental health and well-being. The competencies require in-patient providers to engage patients in setting their

own recovery goals and planning and seek the full participation of significant others in patients' recovery process. Providers acknowledge the valuable information that can be provided by people who know the patient best and respecting that these individuals will likely be patients' sources of hope and other forms of support during the transition to community life.

In addition, providers should demonstrate a holistic understanding of patients by assessing people and their context objectively. The interpretation of perceived deficits within a strengths and resiliencies framework must be emphasized. Applying a strength-based approach can help providers focus on patients' skills, resources, and potentials instead of deficits and weaknesses. This competency extends to providers' abilities to construct elements of the in-patient context to both support the expression and development of strengths. This competency can extend to providers' daily meetings and documentation in which strengths should be reported.

If any stakeholder does not support the patient's recovery, providers can educate that stakeholder and help him or her reframe situations. Effective communication skills are essential in incorporating all different perspectives. An understanding of the emotions and concerns of families in relation to the recovery of their family member is important in tailoring support and education for them. When patients insist on goals that appear unfeasible or have too many goals, providers can help them prioritize their goals and needs, plan concrete next steps, and set individual recovery outcome indicators. If patients have difficulties achieving their goals, providers should have the ability to facilitate a more conducive pace for positive change, supporting their experience of success and comfort in facing challenges.

The high turnover of patients is a challenge in the in-patient setting. There can be limited time for developing collaborative recovery planning. A competent provider is able to rapidly utilize a range of information and reasoning processes to understand patients and engage and sustain involvement with patients. Another time challenge is providers' time constraints because of their heavy caseload and/or

management duties. The time constraints do not allow providers to offer time-consuming services or satisfy different patients' needs at a same time. A group approach can be a solution for these time challenges. However, to meet the recovery principle of individualization, a competent provider is able to organize groups which aim to meet individualized goals for each patient.

### 3.4.3.5 Competencies related to providing choices based on individual needs

**Table 3-8 Challenge 5 and suggested competencies**

<b>Process 2: Provide individually tailored services</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>5. Address the unique needs of patients and find the balance between respecting patients' choices and maintaining ward structure through negotiation of positive risk taking</i>	
<p><b>Challenge 5. Provide choices based on individual needs</b></p> <p><i>Critical tension: It is difficult to address different patients' needs in a restricted environment.</i></p> <ul style="list-style-type: none"> <li>a. tensions exist between patients' needs/rights/choices and the structure of the units</li> <li>b. patients' decisions may lead to harmful/negative outcomes</li> </ul>	<p><b>5. Competencies to engage patients in decision making and satisfy their needs</b></p> <ul style="list-style-type: none"> <li>a. demonstrate an understanding of patients' experiences and be able to negotiate the dilemmas between patients' choices and the ward structure</li> <li>b. promote safety and positive risk taking</li> <li>c. help people articulate their needs and voices</li> <li>d. provide a wide range of options, activities, and education according to patients' needs and current stages of recovery</li> <li>e. encourage patients to make choices and help them through the decision-making process</li> <li>f. engage patients at their own pace</li> <li>g. support patients' interim setbacks after they choose to take risks</li> </ul>

The fifth critical tension (Table 3-8) is the difficulty in addressing different patients' needs in a restricted environment. The in-patient environment provides significant restrictions on daily freedoms, including freedom of choice. Control in the environment relates to pervasive concerns about the potential

for dangerous or other critical incidents. A necessary emphasis on maintaining a safe environment for patients and staff creates tensions between patients' needs, rights, and choices and the structure of the settings. To address these challenges, a competent provider is able to demonstrate an understanding of patients' experiences and focus on patients' unique needs; endeavor to negotiate the dilemmas between patients' choices and the ward structure; and, finally, find the balance through supporting positive risk taking.

Safety can be promoted through risk management rather than risk control. Therapeutic risk taking involves weighing the likelihood of negative consequences followed by an action against potential therapeutic benefits. Recovery can only be achieved by appropriate risk-taking. There might be different views between providers on the assessment of the risk and how best to approach potential risks. Risk can be minimized by skilled and knowledgeable providers who ensure that their practice is a best practice, and who are able to assess the risk and take supportive actions to facilitate learning and change. A competent provider is able to seek to balance therapeutic risk-taking with the need to avoid harm. It is also essential to involve and communicate with patients and families when making decisions with potential positive or negative outcomes. Concerns about risk that are not clearly explicated contribute to the power-imbalance and the climate of control. An effective therapeutic alliance will lead to reduced risk, as well.

Another competency is to help patients articulate their voices to express their needs, and then provide individually tailored services to satisfy these needs. Practices directed to maximizing range of options, activities, and education counteract the restricted nature of the in-patient environment. These need to be accompanied by actions that will activate and mobilize patients to participate, to interact with the environment, and to use resources to their benefit while attending to and respecting autonomy and self-determination.

Patients should be encouraged to make choices and be supported through the decision-making process and demonstrate respect for choices. When providers evaluate patients' decisions as having a potential to lead to harmful or negative outcomes, then competencies oriented to facilitating the collaborative evaluation of choices with respect to their pros and cons can promote informed decision making for both parties. Understanding set-backs experienced by patients in taking risks is an in-patient provider competency that needs to be offered in conjunction with strategies to support moving ahead. Risk taking becomes framed as an opportunity for learning, change, and personal growth even in the context of distress or difficulties.

3.4.3.6 Competencies related to fostering a process of personal hope, empowerment, meaning, and growth cycle

**Table 3-9 Challenge 6 and suggested competencies**

<b>Process 3: Foster recovery</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>6. Foster the positive cycle of hope, empowerment, meaningful life, and personal growth</i>	
<p><b>Challenge 6. Foster a positive recovery cycle</b></p> <p><i>Critical tension: patients can be in a negative cycle of hopelessness, powerlessness, vulnerability, and repeated relapse.</i></p> <p>a. patients can be extremely fragile/have extremely low self-esteem</p>	<p><b>6. Competencies to foster recovery: know best practice of recovery</b></p> <p>a. Hope instillation:</p> <ul style="list-style-type: none"> <li>*help patients and people around them develop or restore hope</li> <li>*convey to patients an understanding of the context of the illness</li> <li>*help patients find meaning in their lives</li> <li>*help patients achieve successful experiences</li> <li>*provide spiritual care</li> </ul> <p>b. Empowerment:</p> <ul style="list-style-type: none"> <li>*know and apply strategies to empower patients</li> <li>*help patients build confidence and positive self-identity</li> <li>*encourage patients to make meaningful contributions to their own recovery</li> </ul> <p>c. Strengths and skills building: enable patients to find their strengths, learn illness/crisis/behavioral management and prevention skills, coping skills, living skills, social skills ...</p> <p>d. Network building:</p> <ul style="list-style-type: none"> <li>* help patients build and maintain more connections, relationships, and resources</li> <li>*connect with the community</li> </ul> <p>e. Readiness in recovery: prepare patients to be ready for their next steps of the recovery processes</p>

The sixth critical tension (Table 3-9) is that patients may be in a negative cycle of hopelessness, powerlessness, vulnerability, and repeated relapse. Some patients may be extremely fragile and have extremely low self-esteem after repeated hospitalizations, disturbances in their community connections,

or a long-term experience of illness. To facilitate recovery, providers must foster the positive cycle of hope, empowerment, meaningful life, and personal growth for patients.

Helping patients and people around them develop or restore hope is imperative. Providers can convey to patients an understanding of the context of the illness, (e.g. that this is but one aspect of their lives). Helping patients find meaning in their lives and opportunities and supports to achieve successful experiences is an example of hope instillation. Providers need hope, as well, particularly given that the in-patient provider's perspective is colored with experiences of people returning to hospital and of acute illness. Meeting with former patients who have moved forward in their recovery in the community is a strategy to help providers become more hopeful and believe in recovery. The strategy of connecting people who have moved on in recovery to the in-patient can be a powerful strategy to enable hope and a sense of possibility.

Providers should know and apply strategies to help patients empower themselves. This can happen both at the level of individual care, but also on the program level. For example, some groups can be co-led by patients. The development of a patient committee in each unit to advise providers about their concerns can be encouraged (Pratt, Gill, Barrett, & Roberts, 2007). This is a way to help patients build confidence and positive self-identity while building in power sharing.

Patients also need skills relevant to social and independent living before re-entering the community. A variety of programs which appeal to patients of different abilities and interests should be provided. In hospitals, the skills patients learn tend to be situation specific and difficult to generalize to the community. For example, the interaction skills patients acquired in the social skill training group may not be adequate for them to cope with complex situations in the community. Therefore, providers must address the transferability of skills and the ways in which skills are learned. The development of illness management skills is particularly important in the in-patient environment. Patients need to be educated

about the nature of their illness, how to monitor their warning signs, how different strategies work to restore their self-control, and how to relieve the side effects of medications.

Recovery is promoted by a support network. Although patients are in the hospital, providers still need to help them build and maintain connections, relationships, and resources in the community. As well, providers have to prepare patients to be ready for the next steps of the recovery processes.

Sometimes patients may hesitate to pursue their recovery goals in response to perceived barriers. A competent provider should be able to assess and develop individual readiness by increasing personal awareness and awareness of alternative environments and prepare patients for the choices and pursuit of goals.

### 3.4.3.7 Competencies related to reducing stigma and providing advocacy

**Table 3-10 Challenge 7 and suggested competencies**

<b>Process 3: Foster recovery</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>7. Take a proactive role in diminishing stigma and promoting recovery in the community</i>	
<b>Challenge 7. Promoting recovery and advocacy</b>  <i>Critical tension: Existing stigmas prevent patients from moving forward.</i>  a. patients' internalized stigma b. social stigma	<b>7. Competencies to promote and advocate recovery</b> a. help patients self-advocate and know their rights b. involve peer-provided services in in-patient settings c. facilitate patients' access to self-help groups d. take a proactive role in reducing stigma, for example, participating in public education

The seventh critical tension (Table 3-10) is the existing stigmas which constrain patients moving forward in recovery. Internalized stigma is a patient's own belief of negative attitudes about him/her self



while external stigma is society's negative attitudes based on misunderstanding or faulty beliefs about serious mental illness. A competent provider should take a proactive role in diminishing stigma as a means to promoting recovery, including awareness of the potential for their own actions to fuel stigma. Reduction of external stigma requires changing the social context. In-patient providers need to be knowledgeable of the philosophical roots of anti-stigma activities derived from a social model of disability and anti-stigma approaches such as public education and protest (Martin & Johnston, 2007; Rüsçh, Angermeyer, & Corrigan, 2005). Likewise, a working knowledge of approaches to enable the reduction of internalized stigma is an integral recovery competency. For example, the social-cognitive perspective stresses the negative self schema and the agreement with stereotypes by patients themselves, and a cognitive-behavior approach has been proved to be effective in changing this negative schema. In addition, internalized stigma and empowerment have been described as two opposite poles on a continuum (Rüsçh, Lieb, Bohus, & Corrigan, 2006; Vauth, Kleim, Wirtz, & Corrigan, 2007). Accordingly, strategies that promote empowerment may diminish internalized stigma.

Involving peer-support services in in-patient settings can be an effective way to promote recovery. Peer-provided services are delivered by peer support workers who are receiving or have received mental health services for psychiatric illness. Peer support workers can create a more respectful and less stigmatizing attitude toward patients, improve services by enabling providers to self-reflect, share their successful coping strategies, and serve as role models to demonstrate the possibility of recovery (Corrigan, Mueser, Bond, Drake, & Solomon, 2008; Doherty, Craig, Attafua, Boocock, & Jamieson-Craig, 2004). Although patients are in the hospital, providers can also introduce them to self-help organizations in the community. Self-help groups, usually initiated by peers, have been developed for individuals to share their problems or issues and to provide mutual support in satisfying common needs that could not be met in the formal mental health system. In self-help groups, patients can derive a sense

of universality, acceptance, support, and empowerment, and develop new attitudes and self-knowledge through a reciprocal exchange with empathetic peers (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). A competent provider is not only able to involve peers or self-help organizations in in-patient settings but also design services that integrate and support such advocacy activities.

#### 3.4.3.8 Competencies related to providing transitional services

**Table 3-11 Challenge 8 and suggested competencies**

<b>Process 4: Transition</b>	
<b>Challenge</b>	<b>Suggested competency</b>
<i>8. Connect patients and significant others to community services and resources they need</i>	
<p><b>Challenge 8. Provide transitional services</b></p> <p><i>Critical tension: Moving from the in-patient to community environment can be a complex transition. In-patients may not have access to supports to connect them to resources and opportunities in the community.</i></p> <p>a. insufficient resources and ongoing support in the community</p>	<p><b>8. Competencies to ensure continuity of care</b></p> <p>a. connect patients to their most significant healing relationships and supports</p> <p>b. anticipate potential problems/issues in making community connections and strategize supports accordingly</p> <p>c. help people solve the problems with their transition planning – finance, housing, relationships, resources ...</p> <p>d. integrate community resources and connect to patients and significant others</p> <p>e. strengthen partnerships with local community services and help patients with transitional processes (referral or follow-up)</p>

The final critical tension (Table 3-11) is based on the need to strengthen and make more accessible the transitional services connecting patients to community resources. Some of the tension comes from the lack of community resources, especially for ongoing support. There may be no community supports or resources available for some patients in some areas of need. To ensure the continuity of the recovery

process, a competent provider should be able to explore and integrate community resources and connect patients and significant others to these resources they need.

In the discharge planning, providers should be able to choose placement and services that capitalize on patients' prior success in the community (Pratt, Gill, Barrett, & Roberts, 2007). Discharge planning is a preparatory exercise designed to ensure a successful transition into the community (Wallace, Robertson, Millar, & Frisch, 1999). A competent provider can plan and coordinate the preparation process and help patients solve the problems with their discharge planning such as finance, housing, and relationships. In some cases, patients can be supported in beginning participation in community activities prior to discharge. While patients are still hospitalized, providers can continue communication with community service providers to maintain patients' previous social resources, such as housing or job issues. In-patient provider competencies include proactively strengthening partnerships with community services to develop innovative approaches to supporting this transition and overcome issues related to some patients "falling between the cracks".

## **3.5 Discussion**

### **3.5.1 Brief summary of the main findings**

This study conducted both a broad synthesis of the literature and multiple interviews with a range of stakeholders to develop a recovery competency framework specifically tailored to the needs of in-patient providers. Two models were developed. The first one was a tension-practice-consequence model addressing key tensions inherent in delivering recovery-oriented services and demonstrating the relationships among these tensions. These tensions, including the environmental level tensions, personal level tensions, and providers' own tensions, cause current practice to be medically orientated with

insufficient engagement of patients, and resulting in hopeless, powerless, and compromised relationships between providers and patients. The second model was a process framework to enable in-patient provider delivery of recovery-oriented services. The four enabling processes are engaging with patients to reduce tensions, providing individually tailored services, fostering recovery, and providing transitional services to ensure continuity of the recovery process.

According to the two models, eight corresponding core competencies with four to ten sub-competencies were identified. These eight core competencies can be organized into the four enabling processes, thus providing in-patient providers with clear guidelines for applying these competencies in their daily practice (see Table 3-12).

**Table 3-12 Summary of the Recovery Competency framework**

Enabling Process	Core Competencies
Process 1: Engaging with patients to reduce tensions	1. Competencies to reduce environmental tensions 2. Competencies to reduce personal level tensions 3. Competencies to reduce providers' own tensions
Process 2: Providing individually tailored services	4. Competencies to set goals and planning and provide individually tailored services 5. Competencies to engage patients in decision making and satisfy their needs
Process 3: Fostering recovery	6. Competencies to foster recovery: know best practices of recovery 7. Competencies to promote and advocate recovery
Process 4: Transition	8. Competencies to ensure continuity of the recovery process

### **3.5.2 Evaluation and interpretation of findings**

The competency framework developed in this study comprises several recovery principles similar to existing recovery competency frameworks. However, compared to existing recovery competency frameworks that are generic and broadly applicable to different mental health service delivery settings,

this competency framework makes a unique contribution to address specific needs of in-patient providers. There are some common characteristics between this competency framework and the Scotland's capability framework for acute mental health care. Both of them address providers' competencies to engage with patients when they are in an acute crisis situation. But their focus is different. The Scotland's acute framework emphasizes acute care within community and hospital settings while the competency framework in this study focuses on the in-patient context including acute and long-term care settings. Some unique differences based on the in-patient context are highlighted specifically in this competency framework. For instance, the in-patient setting features more environmental restrictions than other mental health services settings. In-patient provider competencies incorporate specific considerations of environmental design. Being able to develop more flexible ward routines under restricted conditions, being able to be respectful in manner at the time of security checking involving personal items, and being able to negotiate the dilemmas between patients' choices and the ward structure are examples of context specific competencies required for in-patient providers in this competency framework.

For the competencies to be translated into daily practice, it is necessary to suggest learning activities providers can undertake to develop their knowledge and abilities to deliver recovery-oriented services. The application of competency sets in workforce education is only found in the Scottish series of recovery documents. The 10 Essential Shared Capacities framework consists of six learning modules with specific learning activities incorporated (NHS Education for Scotland, 2007a). The Realising Recovery Learning Materials with more detailed knowledge and skills in recovery focused practice also uses interactive learning involving discussion to enable learners' critical reflection and exploration of practice (NHS Education for Scotland, 2008). These Scottish educational materials provide action focused implications of generic recovery competency sets. In this study, the competency framework can further apply these

learning strategies and extend the specificity to design training programs meeting the unique needs of in-patient providers.

In this study, accessing both scholarship and stakeholders provided sensitivity to many challenges and tensions that exist in the in-patient environment. This approach led to the development of the tension-practice-consequence framework and the recovery enabling framework underlying the competency framework. Roe in 2002 proposed that one of the steps of developing a competency profile is “competence modeling”, which is to draw up a model showing the relationships and dispositions between particular competences, knowledge, skills, and attitudes (Roe, 2002). While the use of competence modeling was suggested in the literature, the existing competency sets in the mental health field have rarely constructed a conceptual framework delineating relationships between competencies. The two models developed in this study are advanced in providing the conceptual foundation underpinning the competency framework. They offer a representation of the complexities and tensions of the in-patient context and a guiding process incorporating recovery concepts into the services.

Tensions have been used as a means to reconcile integration of services in the literature. For example, Krupa & Clark proposed three case scenarios that highlighted day-to-day tensions in the delivery of recovery-oriented services with open dialogue and resolutions to those tensions (Krupa & Clark, 2009). They demonstrated the way to use tensions as a learning opportunity to promote the integration of service delivery. In the study, through the development of the conceptual models and the association between tensions and competencies, this in-patient recovery competency framework could contribute to the development of context specific training materials suggesting how to best negotiate those clinical tensions to support patients’ recovery. Further endeavors may focus on the development of learning activities contributing to competency development.

### **3.5.3 Limitations**

Although some remarkable findings emerged in this study, there are some important limitations that should be acknowledged. One of the limitations involves data collection which took place at only 2 tertiary mental health hospitals. The main findings based on informants from only 2 hospitals may not capture all issues regarding in-patient recovery-oriented service delivery. It is possible that slightly different competencies may emerge if other in-patient settings were considered. For instance, very short-term hospitalization may involve pressure to discharge with conflicting priorities and extremely constrained time and resources. This may suggest the need for other specific competencies required for in-patient providers. Besides, this competency framework does not explicitly consider the presence of complicated mental health issues, such as a developmental disability or substance abuse with emotional, behavioral or psychiatric difficulties that patients might have in some in-patient settings.

Although it is not a limitation of this study, it should be remembered that competencies will not address all issues related to recovery-oriented practices. Developing competencies of providers will not deal with the resource issues that emerged in the study, and may not be enough to deal with management issues, such as manpower shortages and mental health funding cutbacks. Effective services cannot be achieved without management support. Providers need to be empowered to practice recovery within an infrastructure that supports this. If a hospital's design, evaluation, leadership, policy, management, and training are not recovery-oriented, providers' development of recovery competencies and the implementation of recovery-oriented services would not be supported. Changes in institutional structure and routine organization of power in everyday practice are practical ways of engaging both providers and patients in empowerment (Townsend & Morgan, 1998). Although this study does not directly address these system level barriers, promoting an increase of providers' competency at the individual level may have influence at the system level.

### **3.5.4 Implications for practice and future research**

This competency framework supports providers in overcoming clinical challenges in delivering recovery-oriented services, specifically in the in-patient context. An effective provider may be equipped with these competencies through education or training programs. There are a number of ways to use competency profiles to develop professional training. One is to apply the competency profile and raise staff's competency level by learning from daily reflection. This method intends to deepen and extend the existing competencies. Another is to compare the required competencies and the present qualifications and bridge the gap between current state and needs (Roe, 2002). The successful implementation of recovery competencies requires all stakeholders' commitment. Adequate support is important in the learning and changing process. This competency framework encompasses specific professional roles and guidelines. The need for collaboration in the inter-professional education process is essential in order to transcend typical disciplinary boundaries and facilitate recovery in the in-patient setting. The Canadian Collaborative Mental Health Initiative's development of inter-professional education is one example which demonstrates an educational resource to assist in promoting collaborative mental health services (Curran, Ungar, & Prauzé, 2006). Moreover, mental health hospitals might use this competency framework to guide future recruitment and evaluations of their in-patient providers with respect to knowledge of, attitudes about, and skills in various aspects of recovery-oriented services.

This recovery competency framework is developed considering extensive sources of information provided by relevant stakeholders and a wide range of empirical literature. While the competency framework may have preliminary validity, additional attention needs to be directed towards operationalizing these competencies, for instance, values and attitudes. Further validation of this competency framework in daily practice needs to characterize it as a dynamic competency profile being able to meet training needs in different in-patient settings. It can serve as a basis to develop practice



standards or practice guidelines. Research targeting outcome measurements, such as the development of evaluative tools, are necessary to determine the effectiveness of the competency framework.

### **3.5.5 Conclusion**

Providers' level of competency is considered a cornerstone of recovery-oriented services. This study has contributed to the literature by constructing an in-patient providers' competency framework with underpinning conceptual models addressing critical tensions and the enabling processes. Understanding challenges and analyzing tensions that are reflected in the practice are advanced approaches to identify competencies in the study. It appears that further training programs may be effective in developing providers' competencies if they focus on reducing barriers and proposing solutions to tensions in real life practice.

## **Chapter 4**

### **Phase Two: Program Development**

#### **4.1 Introduction**

The promotion of recovery-oriented mental health services has been a worldwide movement, and programs and research in this area are rapidly growing. However, the extent to which recovery-oriented principles have permeated throughout the in-patient context remains limited. The results of Phase One of the study showed that practicing in a recovery-oriented fashion is particularly challenging in in-patient settings. Tensions embedded in recovery-oriented in-patient services included a lack of agreement between patients' needs and choices and the structure of the unit, a lack of recovery competencies among providers, a traditional focus on medical and problem-based models, as well as a negative cycle of hopelessness or repeated relapse of patients. It may be challenging for providers working under these conditions to adopt recovery principles in their daily practice.

In Phase One of the study, a needs assessment was conducted to identify service provider recovery competencies required for in-patient recovery-oriented services and to determine their educational requirements and priorities. For the competencies to be translated into daily practice, it is necessary to provide learning programs for providers to develop their knowledge and abilities to deliver recovery-oriented services. The purpose of Phase Two is to construct a recovery educational program based on the recovery competency framework developed in Phase One tailored to the needs of in-patient providers.

#### **4.2 Background**

##### **4.2.1 Existing recovery educational programs**

Two searches were conducted in order to understand existing recovery educational programs. One used the MEDLINE, CINAHL, PsycINFO, and EMBASE databases to find research reports related to recovery focused educational programs. The other search used Google search engine to look for websites describing recovery-focused educational programs. Keywords used in the searches included *recovery training program, recovery model, recovery education, mental health in-service training, competency, and staff education*. The searches were limited to educational programs for providers. The results suggested that recovery educational programs could be organized into three general categories. The following review presents examples under each category.

The first category includes educational programs developed by agencies or organizations to address the needs of their own service providers. For example, the New York Association of Psychiatric Rehabilitation Services (NYAPRS) has developed a series, “Transformation to Recovery Training”, which prepares staff and organizations to deliver Personalized Recovery Oriented Services in the community. Two major parts of the training package are: 1) building the basic recovery concepts and skills of staff, and 2) building a recovery-oriented program, which contains instructions on the policies and contextual factors related to recovery-oriented services in New York State. This training focuses on developing an operational understanding of service transformation in the context of New York State (NYAPRS Collective, 2011). Another example is the Realising Recovery learning materials developed by National Health Service (NHS) Education for Scotland and the Scottish Recovery Network. The learning materials build on the 10 Essential Shared Capabilities (Scotland), which have been designed to support mental health workers to develop recovery-oriented practice. There are six learning modules covering the topics of understanding recovery, using self to develop recovery focused practice, enabling self-direction, providing person-centred support, sharing responsibility for risk and risk-taking, and connecting with communities (NHS Education for Scotland, 2008).

The consultation and training for systems transformation developed by the Yale Program for Recovery and Community Health (PRCH) is one more example. The PRCH team members provide introductory recovery training for all levels of clinical staff, advanced recovery training for recovery workers, mentors, and leaders, and in-depth consultation on clinical application of recovery-oriented practice. This series can be tailored to meet an organization/system's needs (Yale Program for Recovery and Community Health, 2011).

The second category is short-term training courses. For example, the Medical College of Georgia (MCG) developed a workshop-style curriculum based on defined components of recovery for doctoral-level trained professions (psychiatrists and psychologists) in the academic psychiatric department. This training program incorporated key recovery principles, contrasted the medical model with the recovery model, maintained evidence-based linkages, used language to bridge from traditional care to recovery-based care, and taught skills to be used within the time-limitations of current psychiatric practice. The educational program contained an initial 3-hour workshop centered on an overview of the recovery movement and fostering motivation for recovery-oriented practice, a second 2-hour workshop centered on shifting provider attitudes, and two final panel discussions involving consumers, peer specialists, and experienced recovery practitioners reflecting on their experiences (Peebles, et al., 2009).

The Collaborative Recovery Model (CRM) and its related training program developed by Oades et al. in Australia (Oades, Deane, Crowe, Lambert, Kavanagh, & Lloyd, 2005) is a short-term training course that assists providers to use evidence-based skills with consumers in their recovery-oriented practice in community mental health contexts. CRM consists of two guiding principles and four components, totaling six collaborative recovery training modules as follows: 1) recovery as an individual process, 2) collaboration and autonomy support, 3) change enhancement, 4) collaborative needs identification, 5) collaborative goal striving, and 6) collaborative task striving and monitoring. The

training consists of a 2-day workshop with two 1-day booster sessions at 6 and 12 months after the initial training (Crowe, Deane, Oades, Gaputi, & Morland, 2006; Salgado, Deane, Crowe, & Oades, 2010).

The third category is consumer-led recovery educational programs for service providers. This category of educational programs was designed and delivered by consumers with lived experience. For example, in Queensland, Australia, a 3-day training program focusing on basic recovery concepts, the role of service providers in supporting recovery processes, and the development of recovery-related clinical skills was developed. Training approaches used to promote skill development included didactic lectures, group discussions, demonstrations, and role plays (Meehan & Glover, 2009). Another consumer-led program is “Staff Supporting Skills for Self-Help”. This program was developed by two consumers and involved consumers and providers from across the United States in structured dialogues and focus groups. The major focus is on client-centered care, rehabilitation readiness, self-help, and recovery (Young, et al., 2005).

These three categories of training programs cover generic recovery concepts and competencies required for recovery-oriented services. They translate the large body of recovery knowledge into daily practice and engage providers in building recovery-related skills. Workshops, face-to-face training curricula, facilitated group discussions, panel discussions, and site visits are frequent formats of recovery training. Frequently used educational strategies include consumer presentations, didactic lectures, problem-solving in small groups, individual advice, and role plays. Some of the programs have been proven to increase providers’ knowledge of recovery and create a positive shift in recovery-supporting attitudes. The details of these program evaluations will be reviewed in Chapter 5.

As the majority of current recovery training is generic and community-based, an educational program specifically emphasizing in-patient recovery-oriented practice, and engaging providers in addressing tensions in practice could address a critical gap. Designing education specifically for in-patient

providers is fraught with difficulties. Flexibility of scheduling is one major concern. It is difficult for a group of in-patient providers to leave the unit for training at the same time. In-patient units typically require careful attention to staff coverage level, staff to in-patient ratios, and shift schedules. Education has to be accessible and convenient to reflect this population's particular learning needs. As a result, self-directed learning is an easily portable format to be incorporated into the specific learning structures of the in-patient environment. Allowing providers to learn in a setting and time of their choice in the format of self-instruction package is used in Part One of the recovery education program in this study. However, in order to provide opportunities for interdisciplinary learning and sharing recovery concepts, a group discussion format is used in Part Two of the recovery education program.

#### **4.2.2 Educational theories and andragogies**

Education is a process of imparting knowledge and skill to lead to some sort of change. Educational theories provide frameworks to conceptualize this change process. Andragogy refers to adult learning strategies of knowledge delivery to engage adult learners with the structure of learning experiences. Three education theories and andragogies addressing the development of educational programs for health professionals directed the program design for recovery education.

##### **4.2.2.1 Adult learning theory**

Adult learners seek knowledge for immediate application in solving problems. This concept is applicable to health professionals, who are skilled and experienced and need continuous learning for clinical application (Gaff, Aitken, Flouris, & Metcalfe, 2007). There are four key assumptions about the characteristics of adult learners: 1) learning is self-directed, 2) life experiences provide a rich resource for learning, 3) learning needs are more often determined by life circumstances, and 4) learning is problem-

centered for immediate performance in life circumstances (McAllister, 1997). These assumptions imply that an effective educational program involves encouraging the learner to reflect on past experiences, offering activities which are meaningful to the clinical situation, and focusing on problem-centered solutions. Based on these concepts of adult learning theory, the development of the recovery education program was enlightened by the following two approaches:

1. Case-based approach: Case-based learning focuses on engaging learners in a discussion of real-life situations, striving to solve problems, and finally building knowledge and working together. Learners can identify issues and apply their knowledge to practice situations (Gaberson & Oermann, 2010). This approach is learner-centred and respects learners' experiences. Learning programs which integrate case scenarios into the learning activity in a group setting can help learners explore multiple viewpoints, gain skills from other members, and promote team-based practice.

2. Tension-based approach: Tensions in practice can be viewed as learning opportunities when tensions are identified and reconciled, and potential solutions are integrated into practice (Krupa & Clark, 2009). Tension scenarios can be used as a guide to thought and action because the process of identifying and negotiating tensions is a form of framing that assists learners to recognize and assess the contextual factors at work and fosters well-tailored strategies to change (English, 2002). This approach could meet providers' direct needs in their daily practice.

#### **4.2.2.2 Interprofessional Education**

Interprofessional Education is defined as two or more professions learning with, from, and about each other to improve collaboration and quality of care (Freeth, Hammick, Reeves, Koppel, & Barr, 2005). Facilitating cross-disciplinary interaction is a key learning strategy in Interprofessional Education. Learning may emerge from dialogue and discussion within a group setting. The desired interactive

learning can be achieved through exchange-based learning, in which members exchange knowledge through group discussion, and action-based learning, which involves collaborative enquiry and problem-based project development (Freeth, Hammick, Reeves, Koppel, & Barr, 2005).

An example relevant to this study is an interdisciplinary training program within a psychiatric hospital setting in Israel. Pollard, Gelbard, Levy, and Gelkopf in 2008 implemented an in-service training program aimed at changing staff attitudes in order to support psychiatric rehabilitation. The program content included presentations by consumers and staff from all disciplines, small group processing and open dialogue among all disciplines, as well as community visits. The results showed that after training, staff had an increased awareness of and support for psychiatric rehabilitation. The multidisciplinary staff were able to disseminate information, messages, and goals to others on practical and psychological levels. This interdisciplinary education created a shared vision about psychiatric rehabilitation and facilitated implementation of services according to this vision (Pollard, Gulbard, Levy, & Gelkopf, 2008). Therefore, interactive learning involving interdisciplinary discussion to enable learners' critical reflection and exploration of practice is a key approach to be included in the development of the recovery education program.

#### **4.2.2.3 The Appreciative Inquiry Approach**

The appreciative inquiry (AI) approach, an affirmation process of organizational change that focuses on the positive and creativity as forces for change, is used as a framework to organize the recovery education program. Developed by David Cooperrider in the mid-1980s, AI views an organization from positive perspectives instead of solving problems. AI involves a process in which changes are facilitated through exploration and creation of positive possibility based on strengths. However, it does not mean that problems or challenges are ignored. Instead, AI addresses problems by



shifting the focus and language from deficits to positive perspectives. During the AI process, problem talk is reframed by possibility talk. The focus on exploring positive possibilities can capture people's interest, and is an effective way to engage people more deeply and for a longer period of learning (Preskill & Catsambas, 2006).

The fundamental assumptions of the Appreciative Inquiry approach are compatible with the recovery concepts. The potential of AI as a tool for developing recovery education in in-patient settings is enormous. Both AI and recovery have the following beliefs in common: 1) through communication, people can shift their attention and action away from their problem analysis to lift up worthy ideals and productive possibilities for the future; 2) giving emphasis to appreciating people's strengths rather than concentrating on their problems; 3) promoting movement toward the use of appreciative and strength-based language rather than the use of deficit-based language such as dysfunction, sick, problem, defensive, disability, incompetent, burnout, etc.; 4) AI and recovery are both a non-linear and never-ending process as the steps are repeated and learning is continuous; 5) like recovery, which focuses on a person-centered intervention, AI is a learner-centered approach wherein the instructor serves as a facilitator rather than content expert, and; 6) recovery-oriented services encourage individuals' active engagement in their own recovery journey and emphasize the collaborative relationships between individuals and providers. Similarly, the application of AI in education is highly participatory in nature and supports people's active involvement in learning with a positive focus that promotes mutual trust and respect. Because the distinctive features of the Appreciative Inquiry educational program are affirmative, inquiry-based, improvisational, and strength-based, these features can reduce providers' defensiveness to change, open chances for discussion, and create a positive framework that addresses the potential tensions in delivering recovery-oriented in-patient services. Using collaborative and participative group dialogue, asking only positive questions, and self-reflection are key AI learning strategies to be included in the

development of the recovery educational program. In this study, the AI approach is applied in the second part of the recovery education program to address two real-life dilemmas experienced in the in-patient context.

### **4.3 Methods**

The aims of the recovery education program are to effect change in the attitudes, knowledge, skills, and behaviours of in-patient mental health providers.

#### Step 1: Determination of educational strategies

The following learning principles were incorporated in the design of the educational program: 1) have a multi-disciplinary application, 2) be easily accessible for learners, 3) include participative group dialogue and reflection, and 4) combine case-based learning and tension-based learning relevant to clinical practices with the application of Appreciative Inquiry approach to develop positive strategies for change.

#### Step 2: Determination of content and format

The learning principles and approaches reviewed in the previous section were manifest in and enabled by the design of the education program. In response to the need assessment and the recovery competency framework developed in Phase One of the study, two major parts of the educational program were developed:

Part One: The Self-learning Program consists of a 72-page user's manual and an interactive lesson on DVD. This format was designed for flexible delivery to in-patient providers through self-paced learning. Three chapters are included in the program. Chapter One, the recovery concepts for people with serious mental illness, provides basic information about recovery including different perspectives of

recovery, factors associated with recovery, strategies to promote recovery, measurement of recovery, and recovery-oriented services. Chapter Two, the in-patient context and the delivery of the recovery-oriented services, introduces the tension-practice-consequence model developed in Phase One of the study. Chapter Three, the recovery competency framework, describes the competencies required for in-patient providers. The DVD comprises the content of the three chapters with quizzes at the end of each section. Learners can complete these quizzes and get feedback regarding their answers. It takes about 4 to 5 hours to complete the self-learning program.

Part Two: The Group Learning Program consists of two learning modules, “Encouraging Participation” and “Strength-based Practice”. These two learning modules are constructed to address two real-life dilemmas experienced in in-patient settings drawn from Phase One of the study and apply the 4-D cycle of Appreciative Inquiry approach to manage these dilemmas. The adaptive 4-D cycle is: 1) Discovery: Participants are encouraged to explore the positive possibilities of recovery-oriented practice in their current setting; 2) Dreaming: Participants work together to develop ideas of what the recovery-oriented practice might be; 3) Designing: Participants work together to craft detailed plans based on what they have learned in the discovery and dream phases; and 4) Delivery: The energy moves toward action planning and focuses on participants’ commitment for change (Cooperrider, Whitney, & Stavros, 2003). Through the 4-D cycle of AI, participants are expected to transform their current practice into a recovery-orientation by building on their strengths. At the end of the learning modules, participants review and validate their actions, reflect on what has been learned throughout the process, celebrate accomplishments, and finally, apply the new learning in future practice. The adult learning and interprofessional approaches are evident in the structure of the group; that is, tension-based discussion and interactive action plans.

A facilitator's toolkit provides guidance and resources for facilitators to deliver the group learning program. The number of participants in a group can be 3-10. The approximate time to complete a learning module is 3 weeks. There are 3 group learning sessions required in a learning module. One group learning session per week is recommended. Each session may last for 90 minutes. It takes 6 weeks in total to complete the two group learning modules. The educational program has been reviewed to ensure its consistency with theories.

### Step 3: Production

The final educational package produced includes: 1) a user's manual and a DVD for Part One Self-learning program; and 2) a facilitator's toolkit and group handouts for Part Two group learning program.

## **4.4 The Recovery Education Program**

### **4.4.1 Part One: Self-learning Program (User's Manual)**



**PART ONE**  
**RECOVERY SELF-LEARNING**  
**PROGRAM**

**USER'S MANUAL**



by

Shu-Ping Chen  
Terry Krupa  
February, 2011

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## INTRODUCTION

### Welcome to the Recovery Self-Learning Program!

This user's manual will provide you with the content of this program and help you to running with the DVD.

#### 1 | How to use this self-learning program

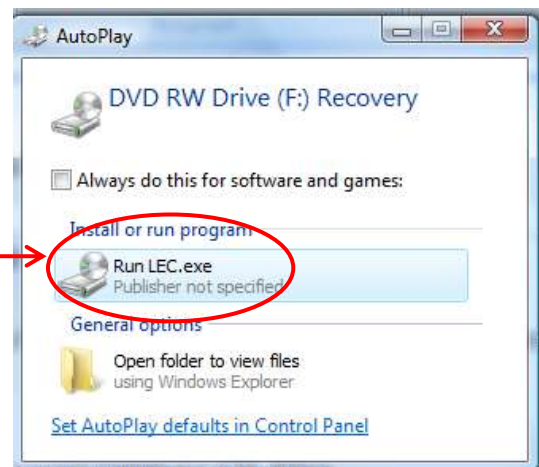
##### 1 | Getting started guide

The following information introduces the main features of the program and the basic steps to get you started. The educational program is named “**LEC**”. It's easy to run the program. We will guide you moving through a series of screens.

Before running the program, please make sure that your computer has “AdobeAIR” to run the program. If you don't have AdobeAIR on your computer, we have included the AdobeAIR on the DVD or you can go directly to <http://get.adobe.com/air/> to download the AdobeAIR program. If you cannot identify whether you have AdobeAir in your computer, please follow the next steps. The system will tell you automatically.

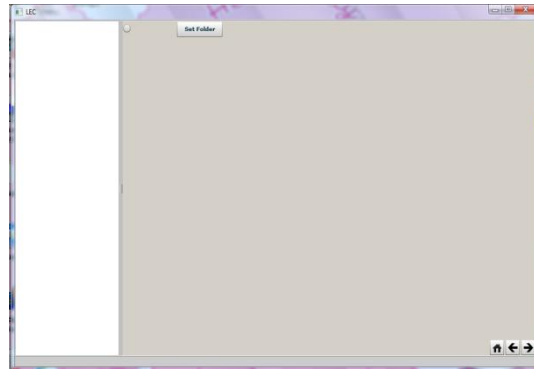
**Step One:** Insert the DVD named “Part One: Recovery Self-learning Program” into your computer DVD drive. You will see “AutoPlay” on the screen or you will see the LEC main screen directly (see next page).

If you see the AutoPlay screen, then click “**Run LEC.exe**” to access the program. Then the LEC's main screen is displayed. It means that you successfully accessed the educational program named “LEC”.





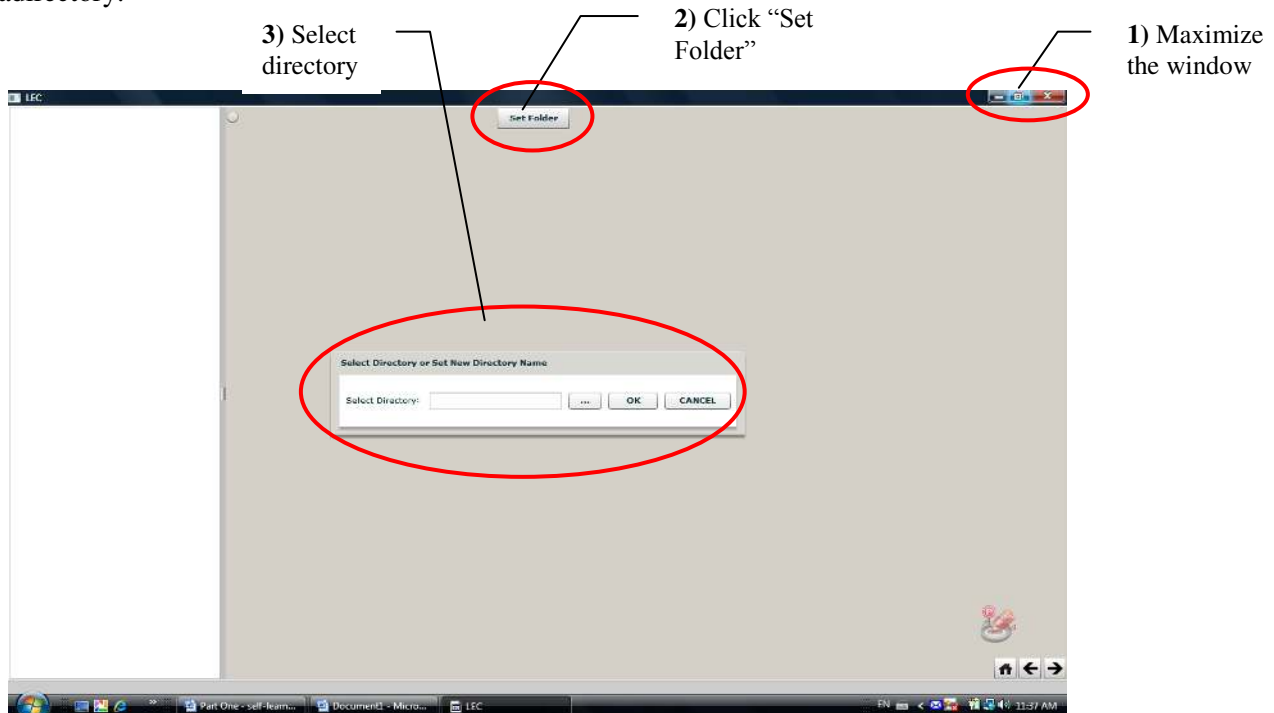
You will see the LEC main screen like this:



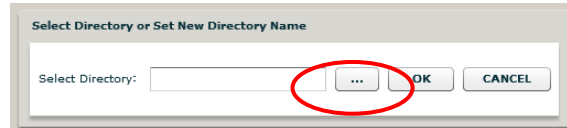
*If the AutoPlay function does not start automatically:  
Go to start → computer → double-click your DVD Drive.*

*If the screen shows: Please install “AdobeAIR” to run the program.  
Go to start → computer → double-click your DVD Drive → select AdobeAIR to download  
the program. Then go back to Step One again.*

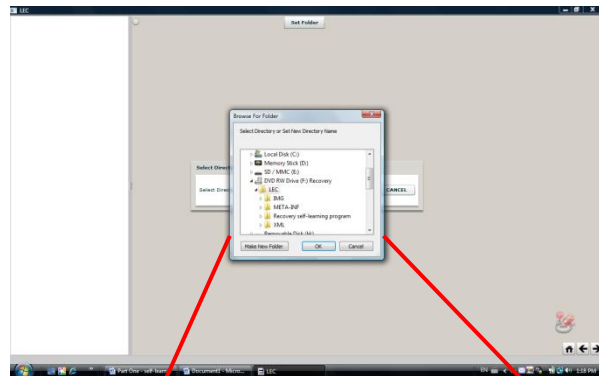
**Step Two:** 1) maximize the window; 2) click “Set Folder”; and then 3) the system will ask you to select adirectory.



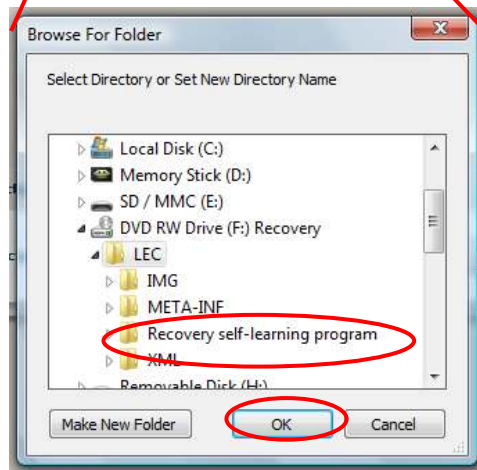
Step Three: 1) click



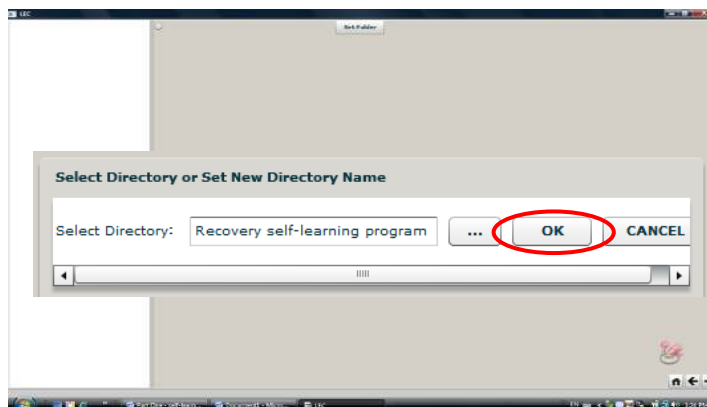
Then you will see "Browse For Folder"



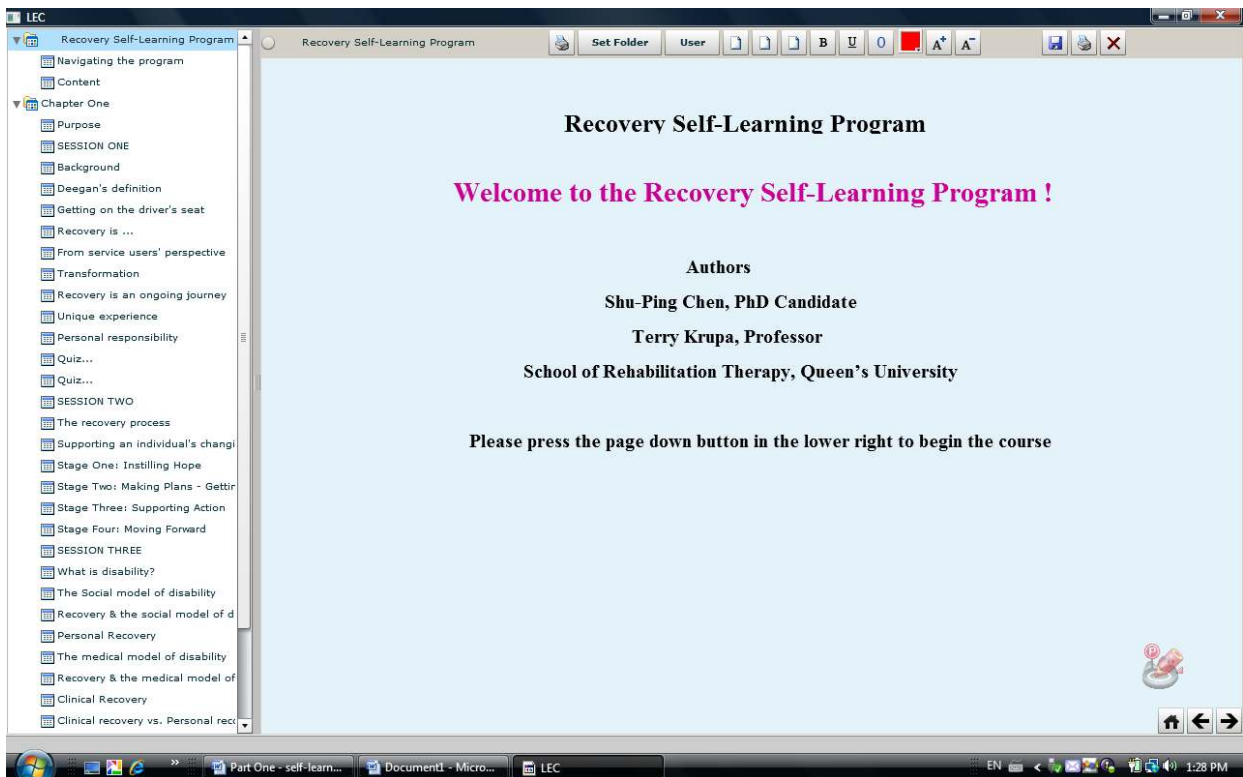
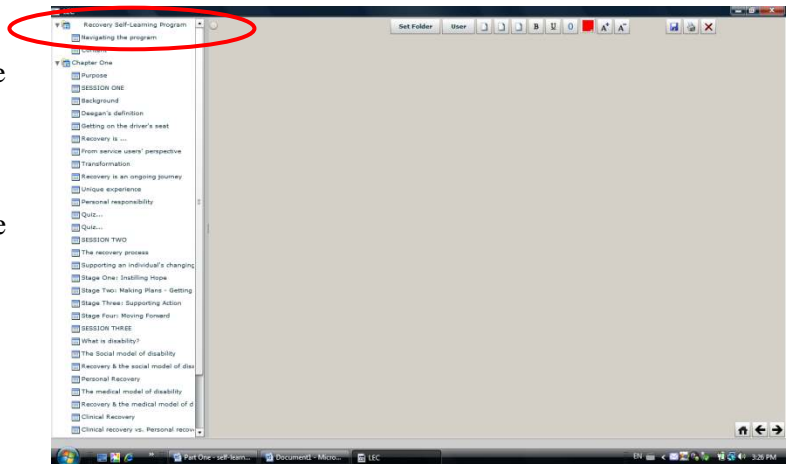
2) Please select "Recovery self-learning program" under the directory of LEC, and then click OK






3) Click OK again



**Step Four:** Now you have entered the Recovery educational program. You will see the outline heading in the left of the screen. Click the top heading “Recovery Self-learning Program”, and then you will see the title page of the program.



## 2 | Navigating the program

This educational program is provided through a series of screens which you can navigate by using the “home” (  ), “page up” (  ), and “page down” (  ) buttons in the lower right of the screen. In addition, you can click on the outline heading in the menu, to the left of the screen, to go directly to the page you wish to access.

You can access and complete this educational program at your own pace. At the end of each session, you will see a quiz which we encourage you to complete. These quizzes are meant to help you integrate your learning. Feel free to revisit the content to help you successfully complete any quiz. The length of time the whole program takes to complete is about 4 to 5 hours.

We hope you enjoy the learning program and that you will find it relevant and useful. If you have any questions regarding the program, please contact Shu-Ping Chen at [6sc56@queensu.ca](mailto:6sc56@queensu.ca).

## 2 | Content

The educational program includes three chapters. The material has been designed to address the specific needs of in-patient mental health providers. All contents in the DVD are shown in this user’s manual.

**Chapter One:** The recovery concepts for people with serious mental illness

**Chapter Two:** The in-patient context and the delivery of recovery-oriented services

**Chapter Three:** The Recovery Competency Framework for in-patient providers

## CHAPTER ONE:

### The recovery concepts for people with serious mental illness

Chapter One will focus on key concepts of recovery including:

Session 1: Definitions and different perspectives of recovery

Session 2: The medical model vs. the social model of recovery

Session 3: The recovery process

Session 4: Factors associated with recovery

Session 5: Strategies to promote recovery

Session 6: Measurement of recovery

Session 7: Recovery-oriented mental health services

Session 8: Promoting recovery worldwide

#### SESSION ONE | Definitions and different perspectives of recovery

##### 1-1 | Background

- In 1988, Patricia Deegan first introduced the language of recovery to the mental health field from the perspective of a consumer.
- The 1990s have been described as the “decade of recovery”. (Anthony, 1993)
- Recovery has been a crucial concept in mental health policy and service system development worldwide.
- The recovery concept has challenged traditional views of serious mental illness

*So, what is recovery?*

## 1-2 | Deegan's definition

*“The concept of recovery is rooted in the simple and yet profound realization that people who have been diagnosed with mental illness are human beings. The goal is to become the unique, awesome, never to be repeated human being that we are called to be. Those of us who have been labeled with mental illness are not de facto excused from this fundamental task of becoming human. In fact, because many of us have experienced our lives and dreams shattered in the wake of mental illness, one of the most essential challenges that face us is to ask who can I become and why should I say yes to life” Deegan, 1996, p.92.*

*Patricia Deegan in 1993 also said:*

*“To me recovery means I try to stay in the driver's seat of my life. I don't let my illness run me. Over the years I have worked hard to become an expert in my own self-care. Being in recovery means I don't just take medications ... Rather I use medications as part of my recovery process ... Over the years I have learned different ways of helping myself. Sometimes I use medications, therapy, self-help and mutual support groups, friends, my relationship with God, work, exercise, spending time in nature – all these measures help me remain whole and healthy, even though I have a disability.” (p. 10)*

## **Getting in the driver's seat! That's recovery!!**

### 1-3 | Recovery is ...

Consider the person with physical dysfunction such as paraplegia; the person might be confined to a wheelchair for the remainder of his/her life. However, the person can live a full life with the disability.

***This is called recovery!***

For people with mental illness, RECOVERY means “growing beyond the catastrophe of mental illness” and “developing new meaning and purpose in life”.

RECOVERY means, a person can live a satisfying, hopeful, and productive life no matter what limitations are caused by illness. (Anthony, 1993)

***We call this: Personal Recovery***

#### 1-4 | From service users' perspective

Recovery is a process of readjusting his/her attitudes, feelings, perceptions, and beliefs about self, others, and their life.

--> It is a process of self-discovery, self-renewal, and transformation.

Deegan in 2001 proposed a term “restitution narrative” which means the wish to return to the former self. It is most often told by people who are recently ill. Speaking of people with serious mental illness, she said: “So, for us, recovery is not about going back to who we were. It is a process of discovering how these limits open upon new possibilities”.

*“Transformation rather than restoration becomes our path”*

#### 1-5 | Transformation

**Transformation** is a key concept here. Recovery is a process of making a shift from illness being central to being more peripheral.

#### 1-6 | Recovery is an ongoing journey

Recovery is an ongoing journey, not a destination.

“We have made some gains and then we find we are repeating the same old behaviors. But that’s OK.

There is a natural resistance to any change process”.

Recovery is a non-linear process. People move forward and move backward. Therefore, setbacks can be part of the long-term recovery process.

*Relapses are not failure!*

## 1-7 | Unique experience

Everybody's recovery journey is unique!! Recovery means different things to different people. It is a very personal experience. You can hear people say:

To me, recovery means ...

- Having a reason to get out of bed
- Realizing that there is more to life than mental illness
- Feeling good about the future
- Believing I can manage my life
- Being loved and accepted as I am
- Getting involved in things I enjoy
- Exploring life outside the mental health system
- Avoiding the things that make me feel bad
- Controlling my symptoms so that they don't get in the way of my life
- Knowing when to ask for help

(Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009, chapter 2)

## 1-8 | Personal responsibility

There is no right or wrong way to recover.

Recovery is a personal responsibility.

You cannot do "recovery" to someone.

Recovery is an individual's own responsibility

We can borrow the Home Depot's old slogan to convey the message to the individual:

**"You can do it. We can help"**

(Davidson, et al, 2009)



---

**Quiz:** *Recovery means*

- A. Going back to previous status.*
- B. No longer taking medication*
- C. Living a satisfying, hopeful, and productive life*
- D. Being able to work full time*

*Correct answer: C (Answer C is correct. Answer A, B, and D are not the definitions of personal recovery.)*

---

**Quiz:** *Who is the person/people most responsible for an individual's personal recovery journey?*

- A. The treatment team*
- B. The person him/herself*
- C. The case manager*
- D. Family members or significant others*

*Correct answer: B (Recovery is an individual's own responsibility)*

## **SESSION TWO | The recovery process**

As recovery is an ongoing journey, the processes of recovery have been developed in a number of “stage models” of recovery. The following table lists some examples of the stage models.

Summary of the recovery process				
Articles	Recovery processes			
Andresen, Oades, & Caputi, 2003	Moratorium → Awareness → Preparation → Rebuilding → Growth			
	Finding hope	Re-establishing identity	Finding meaning in life	Taking responsibility
Jacobson, 2001	Recognizing the problem	Transforming the self	Reconciling the system	Reaching out to others
Spaniol, Wewiorski, Gangne, & Anthony, 2002	Overwhelmed by the disability	Struggling with the disability	Living with the disability	Living beyond the disability
Pettie & Triolo, 1999	Struggle for meaning (Why me?)		→ Reconstruction of a positive identity (What now?)	
Young & Ensing, 1999	Overcoming "stuckness"	→ Discovering and fostering self-empowerment: Learning the self- redefinition & Returning to basic functioning	→ Improving quality of life	

## Supporting an individual's changing process

As providers, how can we support individuals' change process for recovery?

Here we propose four stages for supporting people's recovery.

This information is retrieved from: Realising Recovery Learning Module 3, NHS Education for Scotland.

### 2-1 | Stage One: Instilling Hope

When people are just starting to think about recovery – the possibility of recovery may seem neither possible nor desirable

What we can do is:

- Offer individuals other people's stories of recovery

- Introduce individuals to other people in recovery who have been in similar situations
- Introduce ideas and information about recovery
- Encourage people to think about their life experiences and to start to think about what they want from life
- Create spaces for people to talk about recovery and to think about what it means for them

## **2-2 | Stage Two: Making Plans - Getting Ready**

When people are getting ready to make plans, what we can do is:

- Work collaboratively to identify hopes, fears, dreams, and goals
- Introduce the person to recovery planning tools
- Create conditions to support exploration and planning

## **2-3 | Stage Three: Supporting Action**

When people start to pursue their recovery goals, our supporting actions could be:

- Helping and supporting the person with achieving their plans
- Working alongside people to recognize and build on their successes and to try out alternatives where things don't seem to be working - creativity and perseverance are key components of recovery-focused practice
- Providing important information and knowledge
- Support personal skill development relevant to personal recovery goals
- Supporting people in informed risk taking and acknowledging that mistakes are a normal and useful part of life
- Working alongside people to consider the possible impact of recovery – what will it feel like if things change?

## **2-4 | Stage Four: Moving Forward**

When people move forward, what we can do is:

- Continue to develop person-centered support and planning

- Look for opportunities for peer support
- Build on community connections and social networks
- Discuss setbacks and how they need NOT been seen as “failures” – what can be learned from them as part of long-term recovery?
- Continue to develop self-help and self-management techniques
- Being available to the person – recovery should not necessarily mean the removal of all services and support

*Quiz: When your patient tells you that recovery is impossible for him/her, what you can do is:*

*A. Help and support the person with achieving his/her plans*

*B. Respect him/her and don't talk about recovery in the near future*

*C. Build on community connections and social network*

*D. Introduce the person to other people in recovery who have been in similar situations*

*Correct answer: D (Answer D can offer the person more hope. Answer A and C can be used later when the person is ready to move forward. Answer B is not a recovery-oriented practice)*

## **SESSION THREE | Recovery from the perspective of the social model of disability vs. the medical model of disability**

### **3-1 | What is disability?**

Disability is “an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual and that individual’s contextual factors” (WHO, 2001).

A variety of models has been proposed to explain disability. Here we introduce two influential models and explain their relationship to recovery:

1. The social model of disability

--- > We refer to this perspective of recovery as **personal recovery**

2. The medical model of disability

---> We refer to this perspective of recovery as **clinical recovery**

### **3-2 | The Social model of disability**

*The social model places disability in the context of the environment.*

Disability occurs because society's attitudes and environment are disabling and contribute to disability.

The environment makes the disability apparent.

Thus, disability is largely due to the environment.

### **3-3 | Recovery & the Social model of disability**

Recovery concepts are more rooted in the social model of disability.

- Similar to recovery, the social model of disability stresses people's rights to full participation in society.

Participation is viewed as the collective responsibility of society to remove barriers and make the environmental modifications necessary for social inclusion of people with mental illness.

- Responsibility for enabling participation is societal, for example, advocacy, changing attitudes, reducing structural barriers, changing environment, and providing opportunities and resources.

### **3-4 | Personal Recovery**

From the perspective of the social model, recovery is facilitated when interventions focus on empowering and enabling the individual rather than focusing solely on treating illness and "fixing" individual problems.

### **3-5 | The medical model of disability**

- The medical model views disability as a personal problem, directly caused by a health condition, which requires medical treatment by professionals.

- An underlying assumption embedded in the medical perspective is, although people with mental illness can achieve recovery by being symptom free and high functioning, they still need long-term treatment.

### 3-6 | Recovery & the medical model of disability

- The medical intervention is usually a two-step process: first treat the illness, then rehabilitate the person. (Raging, 2008)

- After illness is controlled by medication, people can benefit from training to acquire their lost skills.
- Continuing maintenance of medication is necessary for symptom control and sustaining functioning.

### 3-7 | Clinical Recovery

From the medical perspective, recovery means that a person shows the amelioration of symptoms and achieves sufficient functioning to resume personal and social activities. (Davidson & Roe, 2007)

“Symptom” and “function” are two major concerns of recovery.

### 3-8 | Clinical recovery vs. Personal recovery

Key features	
Clinical recovery is ...	Personal recovery is ...
an outcome or a state to be arrived at	a continuing journey, a personal growth and developmental process
getting rid of the problem	seeing people beyond their problems
primarily aimed at symptom abatement	primarily aimed at empowerment and self-determination
observable, objective, or operationalisable	subjective experience
rated by the expert clinicians	Expertise of experience
invariant across different individuals	unique and deeply personal
<i>Other terms: Recovery “from” mental illness; Service-based recovery</i>	<i>Other terms: Recovery “in” mental illness; User-based recovery</i>

### 3-9 | Medical-based practice vs. Recovery-oriented practice

Traditional...	Recovery-oriented...
Nothing can be done until symptoms and problems have been alleviated.	Providers can enable individuals to use → their strengths to overcome their symptoms.
If an individual fails to adhere to pharmacological, psychological, occupational, or social interventions, he or she might be non-compliant or lack motivation.	→ The individual may prefer other choices which providers don't think they're best. Don't insist on yours!! Negotiating a mutually acceptable compromise is a better way to foster a collaborative relationship.
Individuals who frequently readmit to in-patient settings or who have a fluctuating mental state may not have progress towards recovery.	→ Recovery is a non-linear process. Accepting failures and setbacks as part of an individual's recovery process!!

### 3-10 | Incompatible??

Are clinical recovery and personal recovery incompatible?

The answer is....

**Clinical recovery is one of several approaches to support personal recovery.**

### 3-11 | Integrating medical and social perspectives on recovery

- Recovery can be seen as a continuum, from a dependent and illness-dominated status to a status characterized by independence, self-determination, and meaningful participation.
- Immediately following an individual's acute relapse in the earlier stages of recovery, the primary emphasis might be on clinical needs but integrate the possibility of developing personal management, social needs and community orientation
- In later stages, the primary emphasis might be on developing personal management and meeting participation needs, while integrating approaches that address clinical or medical issues.

- Providers delivering recovery-enabling practices need to take a broad view that integrates both clinical and personal perspectives of recovery.

*Quiz: Which of the following is not an approach based on the social model of disability?*

- A. Providing training to improve individuals' functional level*
- B. Enabling individuals to use their strengths to overcome social barriers*
- C. Changing attitudes and providing opportunities and resources*
- D. Advocacy*

*Correct answer: A (The social model places disability in the context of the environment. Answer B, C, and D try to change social environment and remove barriers. Answer A is based on the medical model of disability which tries to "fix" the individual)*

*Quiz: Which of the following is not a key feature of recovery-oriented practice?*

- A. Accept setbacks as part of an individual's recovery process*
- B. Get rid of the problem*
- C. Empowerment, self-determination, and personal agency*
- D. Expertise of experience*

*Correct answer: B (The recovery-oriented practice views people beyond their problems)*

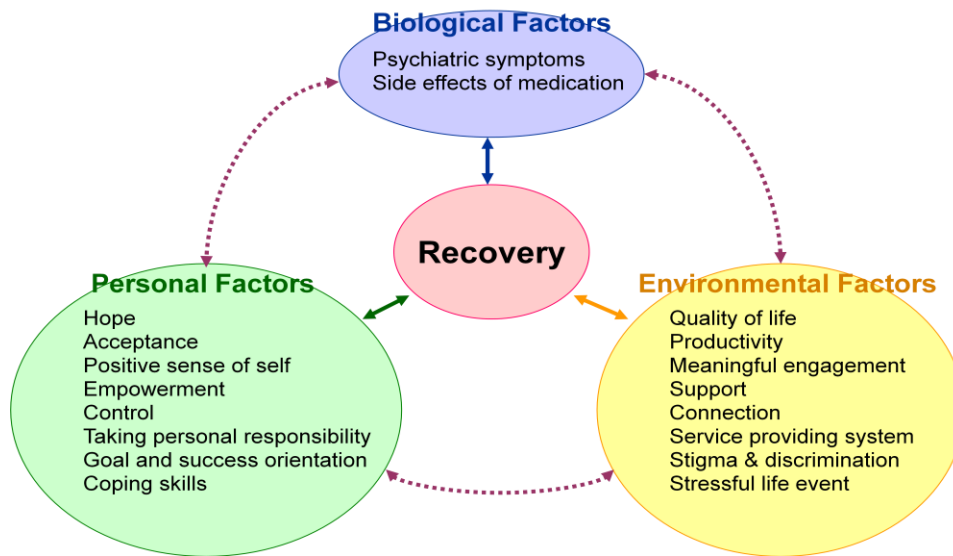
## **SESSION FOUR | Factors associated with recovery**

- In the next pages, factors associated with recovery are introduced.

- These factors were identified from 30 published manuscripts including papers on the concepts of recovery, research, and first person accounts.

The factors have been categorized as: 1) personal factors; 2) environmental factors; and 3) biological factors.





#### 4-1 | Personal factors - Factors associated with the individual

##### 1. Hope

- Hope is a positive outlook on the present and future, a promise that things can and do change.
- Having a sense of hope is the foundation for ongoing recovery from mental illness.
- Having hope may increase motivation and further promote actions.

##### 2. Acceptance

- Recovery begins only when an individual accepts his/her own ability and has self-perception of knowledge about mental illness.

##### 3. Control

- People endorse the recovery experience when they have gained some control to relieve the symptoms of illness, and reduce the social and psychological effects of stress.
- Recovery is that people become active agents and take control in their own lives.

##### 4. Positive sense of self

- Changes in personal identity from a patient to life roles
- Recovery involves rebuilding personal value, self-esteem, and self-confidence

##### 5. Empowerment

- Empowerment means a high degree of self-determination and autonomous decision making exercised by people.

- Recovery is associated with high self-orientation to empowerment.

#### **6. Taking personal responsibility**

- It is each person's own responsibility for health, wellbeing, illness management, and his/her own recovery.

#### **7. Goal and success orientation**

- Expectancy of improvement forms a strong determination to maintain recovery.

#### **8. Coping skills**

- The development of a range of adaptive coping strategies to deal with symptoms of mental illness and daily life stress can assist people achieving recovery goals.

(Jacobson & Curtis, 2000; Mead & Copeland, 2000; Noordsy, et al, 2002; Smith, 2000; Corrigan, et al, 1999; Torgalsbøen, 2005; Liberman, 2002; Merryman & Riegel, 2007)

### **4-2 | Environmental factors**

#### **1. Quality of life**

- One of the elements of recovery is identity of life role, relationship, and recreation.

- Satisfaction with family, social network, living arrangement, and community living may promote people's recovery.

#### **2. Productivity**

- Work participation helps a person structure life, increase meaningful social contacts and social roles, and enhance economic status.

- Participation in work is closely linked to recovery.

#### **3. Meaningful engagement**

- Becoming engaged in activities gives positive meaning to life.

- Meaningful activity could also structure daily life.

#### **4. Support**

- Recovery involves support and partnership. People identify support as a key element in the way of their recovery.

- Support includes family support, mutual support, social support, peer support, formation of support network

### **5. Connection**

- To connect is to find roles to play in the world.

- Building respect, trust, and meaningful interpersonal relationship (friendship, intimate, family) is important in people's recovery journey.

- Connection means willingness to ask for help and reliance on others.

### **6. Service providing system**

- A consumer-oriented service system can facilitate people's recovery rather than a coercive treatment system

- The structure and skill building aspects of psychiatric rehabilitation is a support to recovery.

### **7. Stigma & discrimination**

- People identify both internal and external stigmas of mental illness as one of the most barriers to recovery. Smith, 2000

### **8. Stressful life event**

- Occasional eruptive responses to life pressure can hinder people's recovery.

(Resnick, et al, 2005; Krupa, 2004; Provencher, et al, 2002; Smith, 2000; Ridgway, 2001;

Torgalsbøen,2005; Corrigan, et al, 2004; Merryman & Riegel, 2007)

## **4-3 | Biological Factors**

### **1. Psychiatric symptoms**

The process of recovery may be more challenging for people who have more severe symptoms. (Resnick et al, 2004)

### **2. Side effects of medication**

The right kind of medication could help people effectively manage psychiatric symptoms.

**As individuals gain more insight into their illness, they actively use medication as one of many tools available to cope with their illness.** (Cunningham, et al, 2005)

#### 4-4 | Service user identified factors

Several factors that service users generated as most important to their recovery are:

1. the ability to have hope
2. trusting my own thoughts
3. enjoying the environment
4. feeling alert and alive
5. increasing self-esteem
6. knowing I have a tomorrow
7. knowing with and relating to others
8. increasing spirituality
9. having a job
10. having the ability to work
11. taking responsibility for our own wellness
12. education and knowledge
13. advocating for self
14. peer support

(Mead & Copeland, 2000; Ralph, 2000)

***Quiz:** Which of the following statement is NOT correct?*

*A. Life pressure can help people go through the recovery process.*

*B. Recovery involves rebuilding personal value.*

*C. Having a sense of hope is the foundation for recovery.*

*D. Recovery begins only when an individual accepts his/herself.*

*Correct answer: A (Answer A is not a right statement because occasional eruptive responses to life pressure can hinder people's recovery)*

*Quiz: What is the role of medication in people's recovery?*

*A. Medication is the only way to help people manage symptoms.*

*B. When people recover, they do not need to take medication.*

*C. People use medications as one of many tools available to cope with their illness.*

*D. People should take medication even when they have recovered.*

*Correct answer: C (Answer A, B, and D are not correct. People have the rights to decide their treatment. Medication is one of many tools for their recovery.)*

## **SESSION FIVE | Strategies to promote recovery**

### **People recover, but we can enable!**

Although an individual is responsible for his/her own recovery, service providers can function as a recovery guide to enable people's meaningful participation in achieving recovery goals.

--> People recover, but we can enable!

### **Our Role: Facilitate the individual's process towards recovery**

The following strategies offer practical interventions to promote recovery

#### **5-1 | Responsibility**

Providers can take steps to encourage responsibility. For example, ask an individual in recovery:

1. What are three things you did for yourself during the previous week?
2. What are three things you can do for yourself during the coming week?
3. What are your own feelings and reactions to this exercise?

(Spaniol, Koehler, & Hutchinson, 1994)

- To encourage responsibility providers might say:

*“In the past, you might have waited for experts to fix your problems. Now, you know that, while others can play an important role in your recovery journey, you need to step up and play the main role. You need to be in the driver’s seat!!”*

## **5-2 | Evidence-based practice**

Evidence-based practices are interventions for which there is research evidence of positive outcomes. Current evidence-based intervention recommendations tend to be in line with the recovery concepts. Besides, recovery goals can be used to inform the development of EBPs. (Rodgers, Norell, Roll, & Dyck, 2007)

### **Evidence-based interventions as a contributor to recovery include:**

1. Medication, illness management, psychoeducation
2. Assertive Community Treatment (ACT)
3. Family support, family psychoeducation
4. Supported housing, club house
5. Individual psychotherapy, cognitive-behavioral therapy
6. Vocational rehabilitation, supported employment, and transitional employment
7. Supporting activity-health
8. Case management
9. Skill development
10. Peer support

## **5-3 | Inspiring hope**

Mental health providers can support the development of hope by fostering relationships. (Slade, 2009)

Repper and Perkins (2003) suggest that hope-inspiring relationships involve the following:

1. valuing the person for who they are
2. believing in the person’s worth
3. seeing and having confidence in the person’s skills, abilities, and potentials
4. listening to and heeding what is said
5. believing in the authenticity of the person’s experience

6. accepting and actively exploring the person's experiences
7. tolerating uncertainty about the future
8. seeing problems and setbacks as part of the recovery process and helping the person to learn from and build on these

#### 5-4 | Developing interpersonal expertise

##### **Listening:**

- Authentic listening conveys a powerful message of validation and interest.
- We have to avoid listening that is filtered through the "lens" of our individual perspective.
- Be careful to listen for the individual's perspective.

##### **Self-disclosure:**

- We can use self-disclosure to offer hope or optimism that recovery is possible and help people feel understood.

#### 5-5 | Building collaborative relationships

There are different types of relationships between providers and service users. These relationships lie on a continuum. At one end is an "over-involved" relationship, while there is a "under-involved" relationship lying at the opposite end. In the middle of the continuum is a collaborative relationship, which involves a sharing of power and promotion of working alliance.

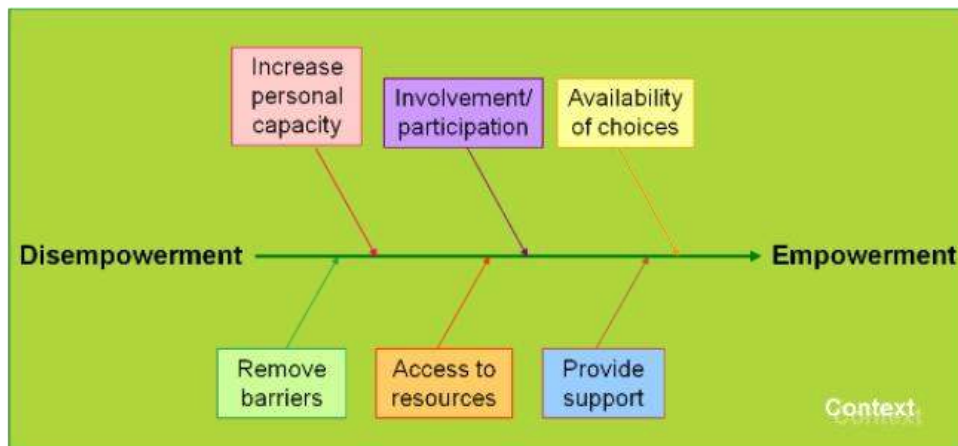


## 5-6 | Empowerment

- Empowerment is a way to enable patients to be active participants in maintaining their own well-being and to take action to achieve influence over their environment . Empowerment enables people to regain a sense of self and facilitates self-expression and self-determination. Empowerment is:

1. **A participatory process** that increases personal control by way of power sharing, that ensures dignity and equality.
2. **An enabling process**, a helping process which enables people to take change of their lives, deliberately making choices and believing the future can be influenced.
3. **An interactive process** through which people experience personal change, enabling them to take action to achieve their recovery goals.

### Strategies that foster empowerment:



## 5-7 | A shift in power position

Providers hold power and have the control in the service providing system. In the hospital, decision-making and communication tends to be top-down.

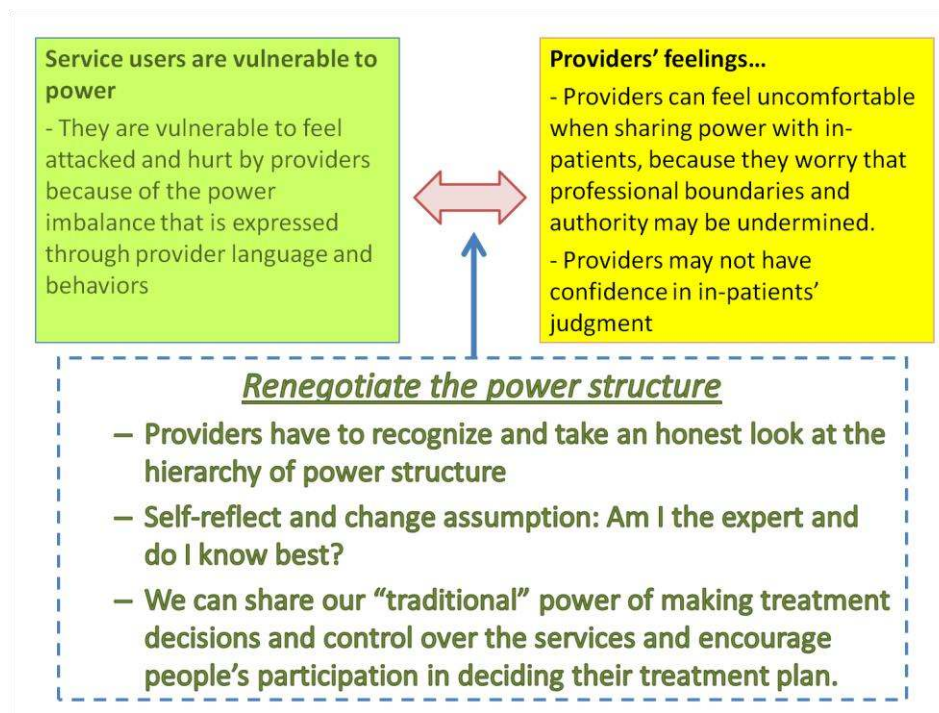


For example, a patient described:

“Providers seem to be the experts on making the best decisions for patients in terms of treatment goals and treatment choices”

However, a primary emphasis of recovery-oriented services is the “expertise-by-experience” of patients with mental illness. Only the person him or herself can define his or her best interests.

## Renegotiate the power structure



When people take back their own power, we may feel that they are “uncooperative” or “non-compliant”.

**In a recovery way of thinking, this is a good sign!!!**

- It means people are thinking for themselves and making their own decisions.
- It doesn't matter whether you think those decisions are best for them.
- Avoid being judgmental or over-protective. The recovery-oriented provider ensures that they are not in any immediate risk and supports individuals as they step out.

## 5-8 | Promoting therapeutic risk taking

Recovery can be promoted through therapeutic risk taking and risk management.

**Point 1: Professionals have a duty to protect the individual and society from danger.**

**Point 2: The individual's right to freedom needs to be balanced with society's right to protection.**

*Risk management and therapeutic risk taking therefore imply that the mental health professional is constantly being pulled by opposing forces. (Stickley & Felton, 2006)*

**So ... How can we change our practice from “risk control” to “risk management”?**

First, we have to introduce the concept of "**risk assessment**".

- A risk assessment is an ongoing process of assessment, review and reassessment, by which a decision on risk to self or others is made by utilising all available information on what is known enabling a balanced summary of prediction.
- Assessment with an understanding of the individual's past achievements and ways of coping is important during the process of risk assessment.

The second concept is "**therapeutic risk taking**".

- Therapeutic risk taking relates to behaviours which involve the individual taking on challenges leading to personal growth and development.
- If risk is defined as the likelihood of something happening that could have potentially harmful or beneficial outcomes, therapeutic risk taking is about having the opportunity to make the choice to follow that course of action. This means staff working from the position of non-expert by enabling people to make a choice about whether they take that risk for themselves.

**Risk management** therefore includes the process of a careful risk assessment and the support of therapeutic risk taking.

- To change our practice from risk control to risk management, we have to think creatively and to work collaboratively with the individual --> needs to be in the context of a therapeutic relationship that provides a vehicle to support people to take risks and make discoveries as part of a natural life process.

(Slade, 2009)

## 5-9 | Strength-based approach

The language of recovery focuses on hope, strengths, and resilience.

The strength-based approach looks at what people can do instead of their problems or deficits.

### **It's not ignoring problems!**

- It's a way of looking at problems through the lens of people's potential, rather than their limitations.
- You can use messages of hope that focus on building strengths and resilience in your daily practice.

### **Recovery Exercise**

The following slides include 2 exercises for you to complete, focus on using recovery language and concepts

**Exercise 1:** Imagine you are working with a client who has been admitted to the in-patient setting.

Try and restate this message in 3 ways so that the language and meaning is more consistent with recovery.

You are functioning at a low level and you need medication.

1	
2	
3	

Suggestions:

	You could say ...
1	While you are at a low point now, there is evidence that you can get better. I suggest you consider taking some medication. We can talk about the options and the pros and cons of each medication. Overall, it might help you feel better. You can use medication as a tool to aid in your recovery.
2	Your current status may be the result of the illness. This doesn't mean that you are going to be sick forever. Lots of people have recovered from the illness. I am sure you can do it!
3	It's normal to feel upset about admission to the in-patient unit. But it's time-limited and you will have the rest of life ahead of you. Try to find your own way of recovery.

Retrieved from:  
<http://www.magellanhealth.com/training/Lesson03/html/index.html>

**Exercise 2:** Imagine the same patient in Exercise 1 asks you:

### ***Will I be normal again?***

	Your recovery-enabling answer is:
1	
2	
3	

Suggestions:

	You could say ...
1	Many people like you go on to live normal, productive lives again. We have lots of ways to help you re-connect with your strengths and abilities so you can begin to recover.
2	Would you like to see the movie, <i>A Beautiful Mind</i> , which is about a person with the same diagnosis who went on to win a Nobel Prize in Economics?
3	You can recover from this illness, but it will take a willingness on your part to work at it. You have been able to accomplish many other things in your life, so I am sure your are capable of doing this, too.

### 5-10 | Peer support services

Peers can contribute to the recovery of others. As an individual said: “The most help I got was from the other people in the ward who had gone through similar experiences”. (Brown & Kandirikirira, 2007)

- Peer support services are services delivered by ex-patients who offer hope, purpose, and meaning for both patients and staff in the hospital.

- Benefits of peer support services: (Slade, 2009)

1. **For peers**, their lived experience is valued, which can be a transformative reframing of an illness experience.
2. **For providers**, peers lead to increased awareness of personal values.
3. **For patients**, exposure to peers provides visible role models of recovery – a powerful creator of hope.
4. **For the mental health system**, peers can promote recovery culture and help the system move toward a recovery-orientation.

---

**Quiz:** Which of the following statement about hope is NOT true?

- A. Hope is the first step in people's recovery.
- B. Hope can help people find their strengths.
- C. With hope, people begin to start looking for their next step of recovery.
- D. Too much hope may bring people out of reality.

Correct answer: D (Having hope means people believe that recovery is possible for them. Hope may serve as a driver to help people move forward. The issue of reality will not be a concern at this scenario because it is hard to define what the reality is.)

---

**Quiz:** How can we help with people's recovery?

- A. Remind people of their strengths
- B. Provide people opportunities to make their own decision
- C. Help people reframe failure into learning experience
- D. All of the above

Correct answer: D (Answer A, B, and C are all strategies of promoting recovery)

---

**Quiz:** Which of the following is not a language of recovery?

- A. When you have some setbacks, it means you didn't pay enough attention to your recovery.
- B. It seems like you are moving forward all the time.
- C. You have really been trying to learn about how to help yourself.
- D. We would like to know your successful experience so we can tell others how to do this too.

Correct answer: A (Answer A: Recovery is a non-linear journey. Setbacks do not mean "failure". Answer B, C, and D convey more hopeful messages.)

**Quiz:** *A good way to explain future expectations to your patients is to say:*

- A. You probably won't recover if you don't take medication and don't participate in activities.*
- B. You need to cut out stresses in your life to prevent setbacks again.*
- C. You need to lower your expectations of yourself because of the illness.*
- D. Lots of people have recovered, and you can too!*

*Correct answer: D (Answer D conveys more hopeful message. Answer A, B, and C are not recovery-oriented answers)*

**Quiz:** *Which of the following roles can peer workers fulfill in the in-patient context?*

- A. Using their own story and experience to model recovery*
- B. Providing hope*
- C. Promoting the use of recovery language*
- D. All of the above*

*Correct answer: D (Answer A, B, and C are all roles of peer workers.)*

## **SESSION SIX | Measurement of recovery**

- Although recovery is not something providers can do to or for people, providers still need to know how people progress in the recovery process.
- In this sense, providers need some instruments to understand people's recovery.

**Using assessment to promote recovery:** (Slade, 2009)

- A recovery-oriented assessment is characterized by “two-way conversation”
- Aims of recovery-focused assessment include:
  1. To promote and validate the development of personal meaning
  2. To amplify strengths rather than deficits

3. To foster personal responsibility rather than passive compliance
4. To support the development of positive identity rather than an illness identity
5. To develop hopefulness rather than hopelessness

In the following pages, we list the measures of recovery in three categories and provide resources to access these measures.

Category 1: Measures of individual recovery

Category 2: Measures of recovery promoting environments

Category 3: Other recovery related measurement

A preview and detailed description of these instruments is appended in the user's manual.

## **6-1 | Category 1: Measures of individual recovery**

### **1. Consumer Recovery Outcomes System Version 3 (CROS)**

<http://www.crosllc.com/>

### **2. Illness Management and Recovery (IMR)**

The IMR Scales are not copyrighted and can be used freely without contacting the author or listed contact.

### **3. Mental Health Recovery Measure (MHRM)**

The instrument may be reproduced freely as long as the author citation and author contact information is retained on the form. Email: [wesley.bullock@utoledo.edu](mailto:wesley.bullock@utoledo.edu)

### **4. Ohio Mental Health Consumer Outcomes System**

<http://www.mh.state.oh.us/oper/outcomes/outcomes.index.html>

### **5. Peer Outcomes Protocol (POP)**

All components of the instrument (Administration Manual; A Question-by-Question Guide, Survey Instrument; Response Cards, and Psychometric Report) are available for free download:

<http://www.psych.uic.edu/uicnrtc/popmanual.html>

### **6. Reciprocal Support Scale**

The Reciprocal Support Scale is not copyrighted and the instrument can be used freely.

### **7. Recovery Assessment Scale (RAS)**



The RAS is not copyrighted and can be used freely.

#### **8. Recovery Measurement Tool Version 4 (RMT)**

The RMT is not copyrighted and can be used freely. There is not a user's fee associated with the instrument; however the author requests data from the instrument's use. Email: ruth.ralph@maine.edu

#### **9. Relationships and Activities that Facilitate Recovery (RAFRS)**

The RAFRS is not copyrighted and can be used freely.

#### **10. Rochester Recovery Inquiry**

For more information contact: Kim Hopper, Ph.D., Nathan Kline Institute for Psychiatric Research

#### **11. Ohio Measures**

##### **(1) Recovery Interview**

Dr. Lesli K. Johnson, Email: Johnson@ilgard.ohiou.edu

##### **(2) Recovery Attitudes Questionnaire (RAQ-7; RAQ-16)**

John J. Steffen, Ph.D., Email: steffejj@email.uc.edu

##### **(3) Personal Vision of Recovery Questionnaire (PVRQ)**

John J. Steffen, Ph.D., Email: steffejj@email.uc.edu

##### **(4) Agreement with Recovery Attitudes Scale**

Sarah Murnen, Email: murnen@kenyon.edu

##### **(5) Mental Health Recovery Measure (MHRM)**

Wesley A. Bullock, Ph.D., Email: wbulloc@uoft02.utoledo.edu

### **6-2 | Category 2: Measures of recovery promoting environments**

#### **1. AACP Recovery Oriented Service Evaluation (AACP-ROSE)**

The AACP ROSE is copyrighted by the American Association of Community Psychiatrists but can be used freely. Email: WSowers@dhs.county.allegheny.pa.us

#### **2. Recovery Enhancing Environment Measures (REE)**

The REE is copyrighted by Priscilla A. Ridgway, 2005. Permission is required from the author prior to using the instrument. Email: priscilla.ridgway@yale.edu

#### **3. Recovery Oriented Systems Indicators Measure (ROSI)**

The ROSI will be in the public domain. Permission is recommended but not required for use of the instrument. Email: so280@columbia.edu; jdumont@lightlink.com

#### **4. Recovery Self-Assessment (RSA)**

The RSA is not copyrighted. Permission is recommended but not required for use of the instrument.

Email: maria.oconnell@yale.edu

### **6-3 | Category 3: Recovery-related measures**

The following are examples of instruments, which measure concepts related to recovery:

1. Leadership Education and Training Assessment
2. Well-Being Scale
3. Mental Health Confidence Scale
4. Herth Hope Index
5. Hope Scale
6. Staff Relationships Scale
7. Making Decisions Empowerment Scale
8. UCLA Loneliness Scale, Version 3
9. Personal/Organizational/Extra-organizational Empowerment Scales
10. Community Living Skills Scale

Resources related to these instruments are appended in the user's manual.

## **SESSION SEVEN | Recovery-oriented mental health services**

What are recovery-oriented mental health services?

- Recovery-oriented services adopt recovery concepts to identify and build upon people's strengths and support them in managing their conditions while regaining meaningful participation in their own lives.
- A recovery-oriented mental health program is characterized by program structures such as mission, policies, procedures, record keeping, and quality assurance that are consistent with fundamental recovery values. (Farkas, et al, 2005)

### **7-1 | System transformation**

- There is increasing recognition that the transformation of mental health systems to a recovery perspective requires collaboration among all stakeholders.
- Changing to a recovery model imposes a fundamentally new set of values and requires that all providers make profound changes in their understanding of the basic task they undertake with those they serve. (Felton, et al, 2006)
- We, as providers, therefore play an important role in the system transformation.

## 7-2 | Recovery culture

How does the recovery culture look?

1. Shared belief that recovery with serious mental illness is possible
2. Shared belief in empowerment and self-determination
3. Shared belief in self-responsibility
4. Shared belief that people with severe mental illness contribute meaningfully to our world
5. Use language that is consistent with recovery

## 7-3 | The values of a recovery-oriented mental health system

Value	Description
Person orientation	The service focuses on individual first.
Personal choice	The service focuses on people's right to make decisions and choice about their own recovery.
Personal involvement	The service focuses on people's right to full partnership in all aspects of their recovery.
Community-focus	The service builds on existing resources in the community and enhances connection.
Focus on strengths and growth potential	The service focuses on a person's existing strengths and inherent capacity to recover

*Adapted from Farkas, et al, 2005 and Spaniol, 2001*

#### 7-4 | Example of a recovery-oriented program design

Program dimensions	Example of value based recovery standard
Mission	To help people be successful and satisfied in the environment of their choice.
Procedures	A detailed list of orientation steps which may be provided in different individualized communication modalities.
Record keeping	Records are designed to include process and outcome measures related directly to the program's mission.
Physical setting	Program facilities are for everyone's use.
Staff training	Staff training includes topics of recovery and interaction with individuals who are living beyond their disability.

*Adapted from Farkas, et al, 2005*

#### 7-5 | Essential services in a Recovery-Oriented System

Service category	Description	Consumer outcome
1. Treatment	Alleviating symptoms and distress Explore and understand recovery	Symptom relief
2. Crisis intervention	Controlling and resolving critical or dangerous problem	Personal safety assured
3. Case management	Obtaining the services clients needs and wants	Service accessed
4. Rehabilitation	Developing clients' skills and supports related to clients' goals	Role functioning
5. Enrichment	Engaging clients in fulfilling and satisfying activities	Self-development Quality of life
6. Rights protection	Advocating to uphold rights, improve services	Equal opportunity Eliminate barriers
7. Basic support	Providing the people, places, and things clients need to survive (eg., shelter, meals, health care)	Personal survival assured
8. Self-help	Exercising a voice and a choice in one's life	Empowerment
9. Wellness / prevention	Promoting healthy lifestyles	Health status improved

From Anthony, W. A. (2000). A recovery-oriented service system: Setting some system-level standards. *Psychiatric Rehabilitation Journal*, 23(4), 159-168.

**Quiz:** Which of the following is NOT an important feature of recovery-oriented service design?

A. Records are designed to include measures related to individuals' problem-solving outcomes.

B. Focus on people's right to make their own decisions.

C. Recognize individual differences and use different individualized communication modality.

D. Use language that is strength-based and consistent with recovery.

Correct answer: A (Answer A is not a recovery-oriented feature. The recovery-oriented records should be designed to include process and outcome measures related directly to the program's mission of promoting recovery.)

## SESSION EIGHT | Promoting recovery worldwide

### National Mental Health Strategies

- The vision of recovery has become the foundation for mental health services worldwide. Many countries have adopted recovery as a basic principle for mental health policy making and service providing system at a national level, for example, Canada, the United States, New Zealand, Australia, the United Kingdom, Ireland, etc.

- North American and Commonwealth countries, led by New Zealand and the US, have established recovery as the basis of system transformation.

\*\* These countries prioritize the recovery concepts in mental health policies.

\*\* Implementation has focused on transforming services and promoting better outcomes and measurable standards.

- Implementation of recovery varies as countries come to grips with different challenges. (Piat, Sabeti, & Bloom, 2010). The next pages will provide examples of recovery-oriented policies/services in some countries.

## 8-1 | Canada

### **National Level**

The Standing Senate Committee on Social Affairs, Science and Technology declared that “recovery must be placed at the centre of mental health reform” in the report on transforming mental health, mental illness, and addiction services (The Standing Senate Committee on Social Affairs, Science and Technology, 2006, Section 3.2, ¶ 3).

### **Provincial level**

Example: Ontario

- The Ontario Provincial Forum of Mental Health Implementation Task Forces has promoted a recovery-based mental health reformed system since 2002.
- Some key recovery-focused principles are identified in Ontario’s mental health policy, Making It Happen (1999).

### **Resources:**

1. Family Outreach & Response Program:

<http://familymentalhealthrecovery.org/>

2. Psychosocial Rehabilitation Canada:

<http://www.psrrpscanada.ca/>

3. Canadian Mental Health Association:

[http://www.cmha.ca/bins/content\\_page.asp?cid=284-683-1480-1497-1556&lang=1](http://www.cmha.ca/bins/content_page.asp?cid=284-683-1480-1497-1556&lang=1)

## 8-2 | USA

- A dozen states had already been promoting recovery-oriented mental health system by the mid-1990s.
- All 50 states quickly adopted recovery mission statements and were implementing at least one evidence-based service following publication of the 2003 Commission Report. (Lutterman et al, 2003)

- The Substance Abuse and Mental Health Services Administration (SAMHSA) unveiled a consensus statement outlining principles necessary to achieve mental health recovery (2006).

([www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov))

\*\*“Recovery must be the common, recognized outcome of the services we support”

\*\* The 10 Fundamental Components of Recovery include:

Self-Direction, Individualized and Person-Centered, Empowerment, Holistic,  
Non-linear, Strengths-Based, Peer Support, Respect, Responsibility, and Hope

### Example (system level): New York State

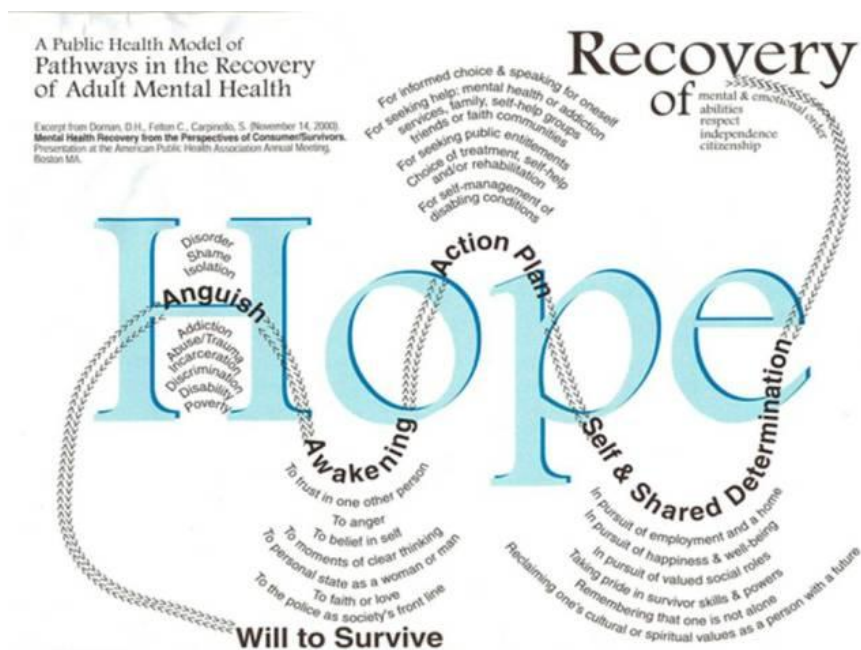
Focusing on recovery in New York State

- The core of recovery-oriented service delivery is consumer- and family-driven individual services planning. Consumer-run programs in the State that also play a critical role in care coordination including a large network of clubs, employment and other recovery-oriented programs.

- The public health model (see the figure) developed and presented in 2000, has been important in orienting the system of care toward recovery and guiding the development of strategies to imbue recovery principles into day-to-day practice.

(<http://www.omh.state.ny.us/omhweb/statewideplan/2006/html/chapter04.html>)

A public health model of pathways in the recovery of adult mental health, New York State, 2000:



### **Example (hospital-based): New Jersey & California**

“Although the recovery model is most often associated with non-institutional settings, recovery-oriented practices are still relevant and essential in the state hospital environment. Currently, state hospitals across the country are moving toward the recovery model paradigm” (Fisher & Chamberlin, 2004)

Examples:

New Jersey: A program targets situations where the system has been unable to successfully discharge individuals into the broader community.

California: Individuals work with their “Wellness and Recovery Planning Team” to develop their recovery plans upon admission.

### **Resources:**

1. National Empowerment Center: PACE program...

<http://www.power2u.org/>

2. Recovery to practice resource center:

<http://dsgdev2.dsgonline.com/rtp/>

3. Center for Psychiatric Rehabilitation

<http://www.bu.edu/cpr/>

4. Mental Health Recovery & WRAP:

<http://www.mentalhealthrecovery.com/aboutus.php>

5. Ohio Department of Mental Health Recovery:

<http://www.mhrecovery.com/>

6. The Yale Program for Recovery and Community Health (PRCH):

<http://www.yale.edu/PRCH/>

7. Mental Health Center of Denver, Reaching Recovery:

<http://www.reachingrecovery.org/>

8. Alaska Mental Health consumer website:

Recovery from mental illness resource: <http://akmhcweb.org/recovery/rec.htm>

9. The Department of Mental Health and Addiction Services (DMHAS), Connecticut:

<http://www.ct.gov/dmhas/site/default.asp>



## 8-3 | UK

- “Mental health services need to change radically to focus on recovery”.
- “Traditional services wait until a person's illness is cured before helping them to get their life back”. Recovery-focused services aim from day one to help people to build a life for themselves.
- A number of Scottish policy initiatives support the move towards recovery-oriented practice. These include the Mental Health (Care and Treatment) (Scotland) Act 2003 and the National Programme for Improving Mental Health and Well-being and the related NHS Education for Scotland programmes for action Delivering for Health and Delivering for Mental Health.
- While this move needs to take into account a wide range of factors, such as the design of mental health services, the development of recovery competencies focuses on the skills, values, and knowledge mental health workers need to facilitate recovery.

### **Resources:**

1. Center for Mental Health, UK:

[http://www.centreformentalhealth.org.uk/across\\_mh/recovery\\_resources.aspx](http://www.centreformentalhealth.org.uk/across_mh/recovery_resources.aspx)

2. Scottish Recovery Network:

<http://www.scottishrecovery.net/>

3. Recovery Devon

<http://www.recoverydevon.co.uk/>

4. NHS Education for Scotland

<http://www.nes.scot.nhs.uk/initiatives/mental-health/publications>

## 8-4 | New Zealand

- The recovery principles have been set out in the Mental Health Commission’s Blueprint for Mental Health Services in New Zealand
- Since 1998, all mental health services in New Zealand have been required by government policy to use a recovery approach and mental health professionals are expected to demonstrate competence in the recovery model. (New Zealand Mental Health Commission).

- In New Zealand, good consumer-provider relationships are identified as a key quality indicator for recovery-oriented services.
- Develop “Recovery Competencies for New Zealand Mental Health Workers” in 2001 by the Mental Health Commission, NZ (O’Hagan, 2001)

**Resources:**

1. Mental Health Commission, New Zealand

<http://www.mhc.govt.nz/>

2. Recovery Competencies for New Zealand Mental Health Workers

[http://www.maryohagan.com/resources/Text\\_Files/Recovery%20Cometencies%20O'Hagan.pdf](http://www.maryohagan.com/resources/Text_Files/Recovery%20Cometencies%20O'Hagan.pdf)

## 8-5 | Australia

At a national level, Australia has explicitly adopted recovery as a basic principle for mental health services.

- “Recovery is a major principle of the *National Mental Health Plan 2003-2008* (Australian Health Ministers, 2003), where it is stated that “A recovery orientation should drive service delivery”.

- Australia's National Mental Health Plan 2003-2008 states that services should adopt a recovery orientation although there is variation between Australian states and territories in the level of knowledge, commitment and implementation (Rickwood, 2004).

**Resources:**

1. O’Hagan, M. (2004). Recovery in New Zealand: Lessons for Australia?

<http://www.familymentalhealthrecovery.org/conference/handouts/Workshop%2010/OHagan%201%20Recovery%20in%20NZ.pdf>

2. Rickwood (2004). Recovery in Australia: Slowly but surely.

<http://www.auseinet.com/journal/vol3iss1/rickwoodeditorial.pdf>

## CHAPTER TWO:

### The in-patient context and the delivery of recovery-oriented services

In Chapter Two, we will introduce a model, the “**tension-practice-consequence model**” that defines some particular issues to be considered in delivering recovery-oriented practice in the in-patient context.

Session 1: Tensions inherent in delivering recovery-oriented services in the in-patient context

Session 2: Current actions and practice

Session 3: Consequences

#### **Background**

- Since the mid-1960s, Canadian mental health policies have moved from hospital-based care to greater emphasis on community-based mental health care. Psychiatric hospitals have been downsized or closed.
- However, recovery is a continuous and non-linear process, occurring even when an individual experiences intense forms of health services, such as hospitalization.
- Although recovery is largely conceptualized as movement towards a full and meaningful community life, a substantial number of people living with mental illness continue to experience hospitalizations in their recovery journey.
- As a result, in-patient settings still serve a significant function in the mental health system and can be a critical part of an individual’s recovery process.

#### **The tension-practice-consequence model**

Through a systematic qualitative study, a tension-practice-consequence model was developed by the authors of this education program. The model identifies several points of tension in delivering recovery-oriented services in the in-patient context

In this model “tension” refers to a situation where service-providers are faced with situations where they are constrained in their ability to provide recovery-oriented services.

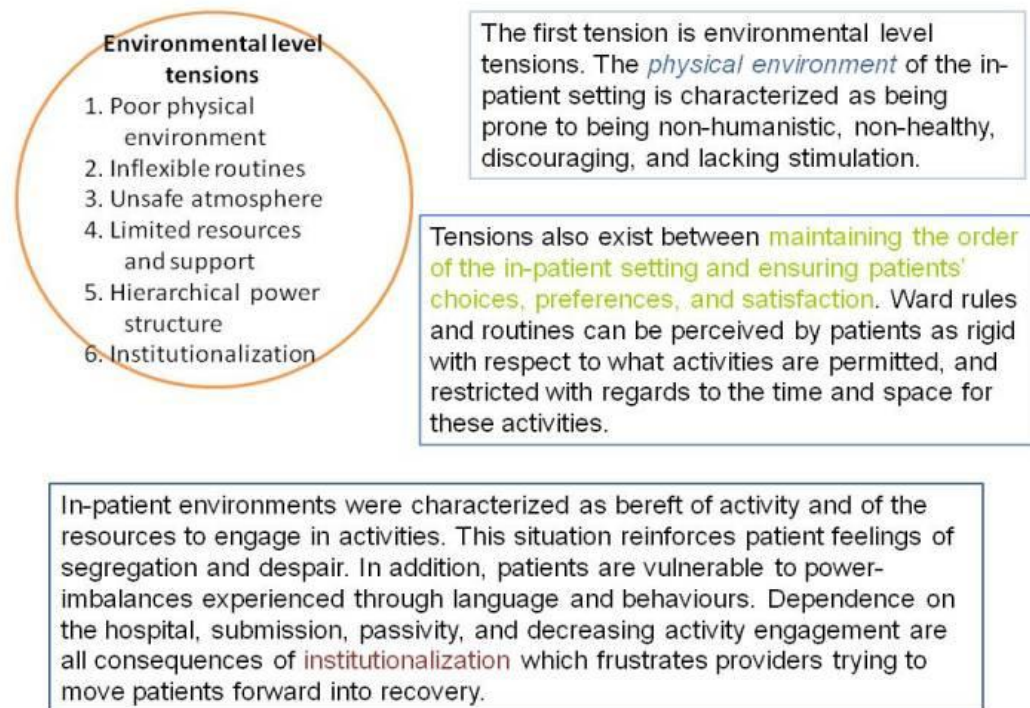
We will introduce you to “**The tension-practice-consequence model: Tensions inherent in delivering recovery-oriented services in the in-patient context**” in the following pages.

## SESSION ONE | Tensions inherent in delivering recovery-oriented services in the in-patient context

In this model, three major points of tension were identified:

1. Environmental level tensions
2. Personal level tensions
3. Providers' own tensions

### 1-1 | Environmental level tensions



## 1-2 | Personal level tensions

### Personal level tensions

1. Psychotic symptom
2. Behavioral problem
3. Cognitive impairment
4. Emotional distress
5. Lack of motivation
6. Refractory to treatment
7. Side effects of medications

The second tension is personal level tensions which refer to patients' psychotic, behavioral, cognitive, emotional, motivational, or medical issues caused by the mental illness.

The level of acuity of mental illness can affect functional capacity and challenge the ability to promote recovery. In this situation greater attention is paid to safety issues in response to the mental instability of the patients served.

The side effects of medications challenge recovery enabling practice. Taking medication regularly was described as a significant way to recover. However, patients expressed that at times the side effects were worse than the symptoms of the illness. They described how their concerns about medications are not always addressed in the in-patient context. **Patients can have limited access to alternative sources of information and support regarding the role of medication in their recovery.**

## 1-3 | Providers' own tensions

### Providers' own tensions

1. Various recovery competencies
2. Inefficient knowledge transformation
3. Pressure, tension, frustration
4. Low motivation
5. Inadequate colleague support
6. Negative belief toward SMI

The third tension is providers' own tensions. **The level of recovery competencies of providers varies widely.** Because the medical model is a pervasive framework for understanding and solving problems, greater importance is placed on medication, relative to other potential practices for recovery support.

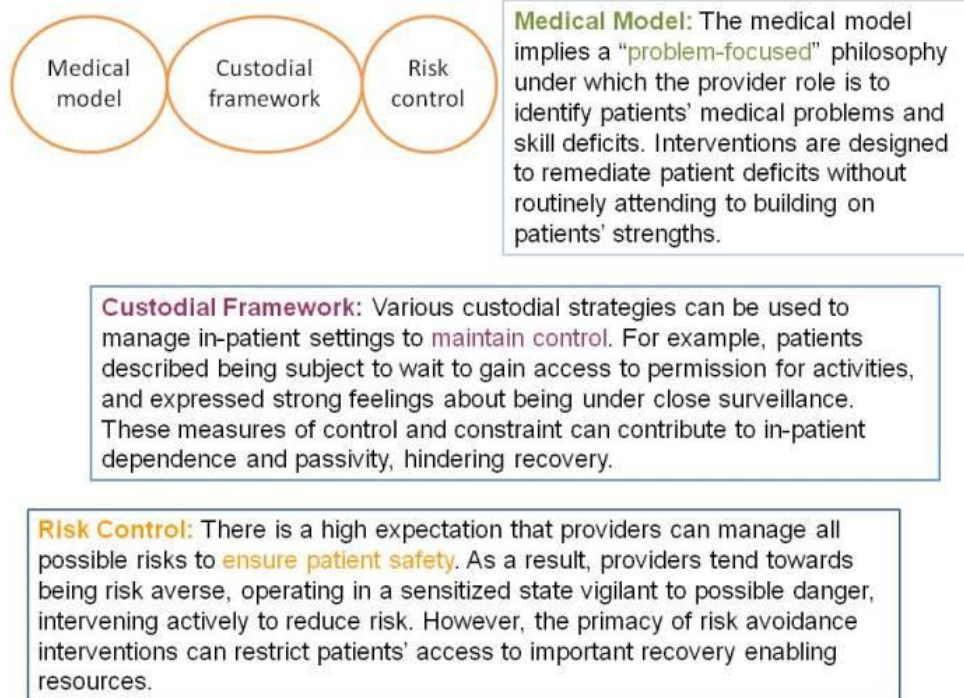
Providers may feel **pressure, tension, and frustration** within the in-patient context. Frustration can result from patients' readmission, and the resulting implication of failure. Providers can also experience a sense of **conflict** between their perceived role in protecting human rights and delivering therapeutic interventions.

Efforts to advance recovery practices can be hindered **by limited support by colleagues and a lack of effective team work** to facilitate recovery. Sometimes, the team culture perceives patients as incapable and providers have a tendency to act as **problem solvers**, dominating the decision making process. Presuming that these acute conditions compromise the judgement of patients can lead to unintentionally discrimination and limit opportunities and autonomy for in-patients.

## SESSION TWO | Current actions and practice

The three levels of tensions compromise recovery-enabling services through their potential to lead to routine and uncritical application of the medical model, a custodial framework, and risk-control principles, which generates a sense of segregation and restriction among inpatients, limits choices, constrains communication, and causes passivity.

### 2-1 | Medical model, Custodial framework, Risk control



## 2-2 | Limited engagement

Limited engagement:  
segregation, restriction,  
constrained communication,  
passivity of patients

A strong sense of **segregation and restriction** emerged around patients being unable to get personal belongings, visit friends, do activities, or be involved in their treatment planning.

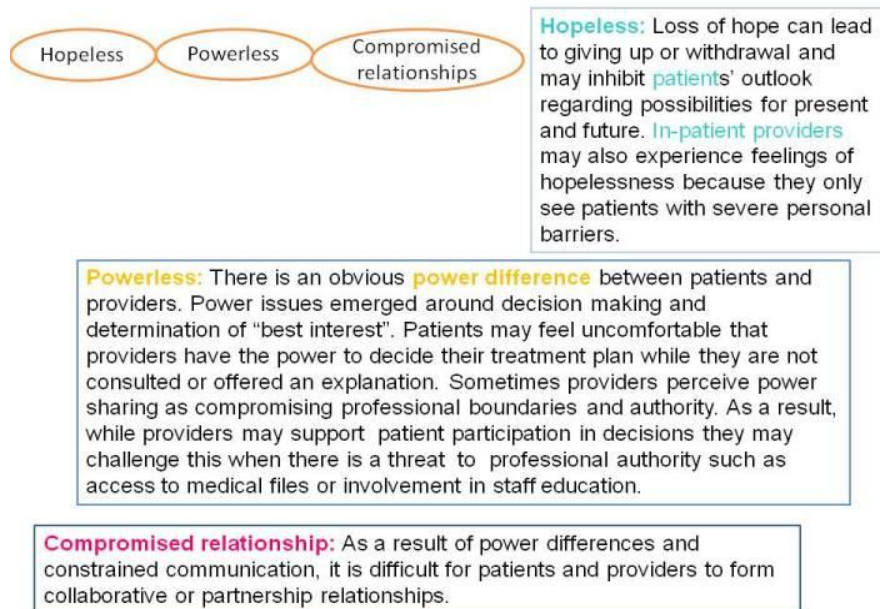
Patients and family members expressed a need for more activities, stimulation, and training. Inactivity was a contributing factor to depression and disorientation. **However**, providers raise concerns about the challenges in engaging patients in activity, in particular concerns about being perceived as coercive in efforts to exhort patients to action and participation.

The in-patient setting is characterized as tending to have few protected channels through which patients can articulate their voices and insufficient communication, which compromises patients **getting information and exercising choices**. With constrained communication, patients are not offered choices or given choices **within a prescribed range** by providers.

## SESSION THREE | Consequences

As a result of the tensions and practices, relationships between providers and patients can be characterized by a sense of hopelessness and powerlessness.

### 3-1 | Hopeless, Powerless, Compromised relationships

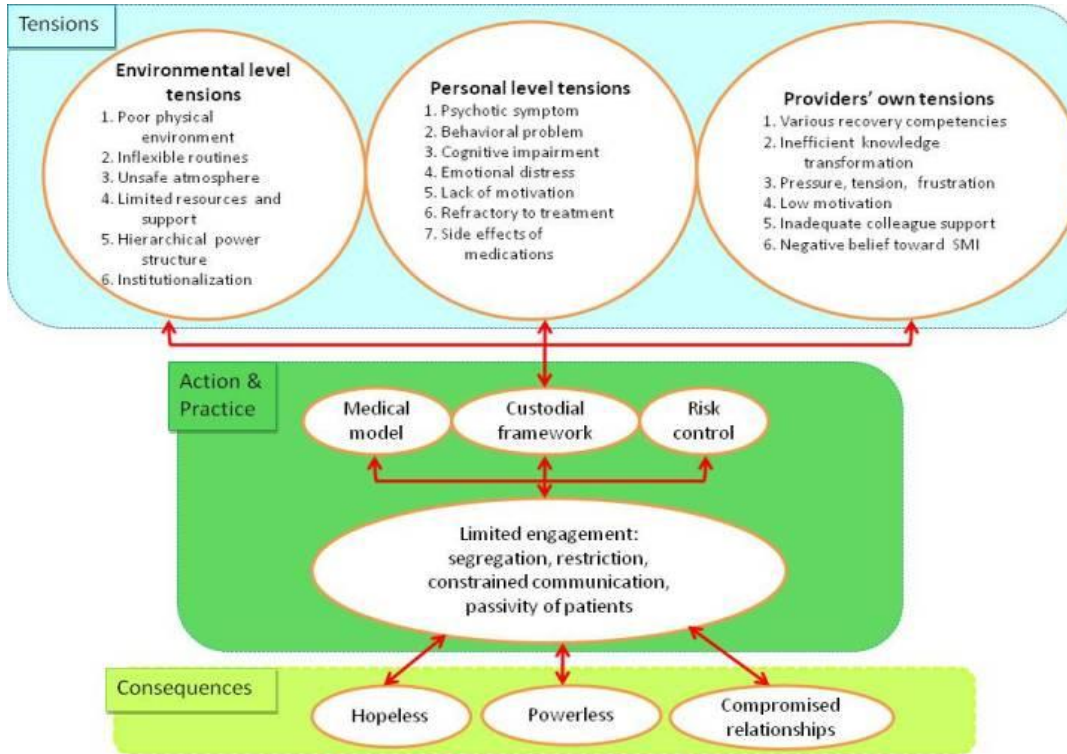


#### Summary of the model

- Resulting from the three levels of tension is an in-patient practice dominated by a medical model of care, risk control, and a custodial framework. These three approaches contribute to the in-patients' experience of segregation and restriction and also reinforce their passivity. Limited choices and constrained communication with providers are related social relations experienced in this context. Finally, hopelessness, powerlessness, and compromised relationships between patients and providers can be identified as clinical consequences.
- All factors illustrated in the model have mutual relationships. Thus the consequences may negatively reinforce the practice, and the practice may increase the level of barriers.



This diagram illustrates the whole model:



The tension-practice-consequence model demonstrates a cycle of in-patient practice, which is not actually a recovery-oriented service.

As one way to change these circumstances, we propose a recovery competency framework in Chapter Three to enable in-patient provider delivery of recovery-oriented services.

## CHAPTER THREE: The Recovery Competency Framework

This chapter will guide you to answer this question:

*What are the most salient components of recovery competencies required for in-patient providers in delivering recovery-oriented services?*

There are two sessions in this chapter:

**Session 1:** The recovery enabling framework for in-patient providers

**Session 2:** The Recovery Competency Framework

### **First, let's listen to what service users said ...**

The Ohio consumer group developed a set of statements to rate the impact of mental health professionals on their recovery. Clients rated these from most to least impact:

1. Encourage my independent thinking
2. Treat me in a way that helps my recovery process
3. Treat me as an equal in planning my services
4. Give me freedom to make my own mistakes
5. Treat me like they believe I can shape my own future
6. Listen to me and believe what I say
7. Look at and recognize my abilities
8. Work with me to find the resources or services I need
9. Are available to talk to me when I need to talk to someone
10. Teach me about the medications I am taking. (Ralph & Lambert, 1996; Ralph, Lambric, & Steele, 1996)

### **Before proceeding, a brief self-reflection exercise ...**

Do you demonstrate the following recovery-oriented qualities in your daily practice?

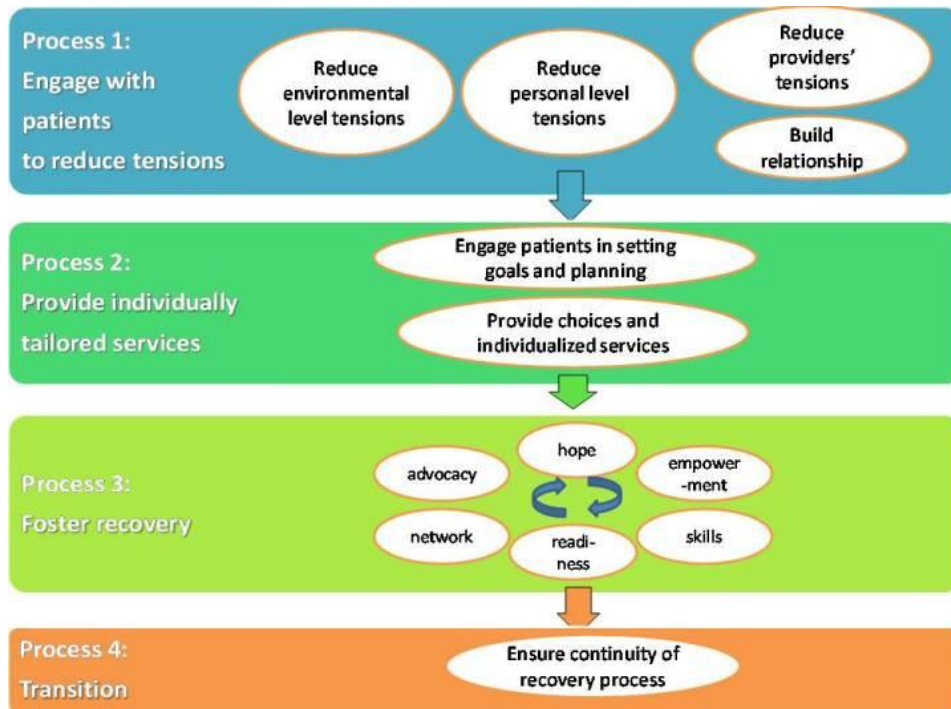
Qualities	yes	no
Listening		
Interpersonal qualities (caring, patience, humility)		
Belief in recovery and encouragement of change		
Focus on the individual		
Understanding people from different backgrounds		
Knowledge about illness, interventions, and resources		
Bringing out the person's strengths		
Live experience (good life skills and experience)		
Non-judgemental attitude		
Sense of humor		

## SESSION ONE | The recovery enabling framework for in-patient providers

To transform in-patient services toward a recovery-orientation, the tension-practice-consequence model can be used as a guiding framework. Another framework, “The recovery enabling framework for in-patient providers”, is proposed here to enable in-patient provider delivery of recovery-oriented services (see figures in the next page).

There are four processes in this enabling framework:

- The first process is engaging with patients to reduce the environmental, personal, and provider levels of tensions.
- The second process is providing individually tailored services, including engaging patients in setting recovery-oriented goals and planning and providing individualized services.
- The third process is fostering recovery, comprising hope instillation, empowerment, skill building, preparation for readiness, network building, and advocacy.
- The fourth process is providing transitional services to ensure continuity of the recovery process.



### 1-1 | Process One: Engage with patients to reduce tensions

- Process One is engaging with patients to reduce tensions to recovery. The framework here highlights the importance of engagement. Engagement involves making contact with patients, attending to their needs, and providing a range of opportunities in the in-patient setting.

- Of particular importance in promoting engagement is: 1) provider awareness of, and sensitivity to, the very fine line between persuasion and coercion and 2) attention to the power differential between providers and patients and the factors which can undermine personal choice.

- For patients, engagement is not only a goal, but also a necessary process on the path to recovery. Reducing barriers at the environmental level, personal level, and providers' own level to enabling recovery depends on collaborative partnerships between stakeholders.

## 1-2 | Process Two: Provide individually tailored services

- One of the critical recovery values is being person-centered referring to services that focus on the individual first rather than focus on the person as his/her illness. Recovery-oriented services may highlight the significance of recognizing and responding to individual differences of each patient.
- This value provides a fundamental orientation for providers in practicing recovery-oriented services.
  - \*\* First, providers engage patients in setting their own recovery goals and planning, and help them work towards these goals.
  - \*\* Second, the in-patient providers have to address the unique needs of patients and find the balance between respecting patients' choices and maintaining the ward Structure.

## 1-3 | Process Three: Foster recovery

Fostering the positive cycle of hope, empowerment, meaningful life, and personal growth is central to recovery.

Strategies providers can use to facilitate recovery:

- 1. Hope:** To instill hope, providers can convey belief in patients and envision future lives for them even when they are hospitalized.
- 2. Empowerment:** Empowerment can be achieved through sharing information and power and improving communication.
- 3. Skill development:** To link between the in-patient environment and the skills required for community, providers require an understanding of patient lives in community and adapt the in-patient setting to create an environment where these skills will be developed and used.
- 4. Network building:** Providers can help patients identify their valued social roles as well as build and maintain more connections, relationships, and resources.
- 5. Readiness:** Providers can facilitate and support patients' desire or motivation to act to pursue their goals.
- 6. Advocacy:** Providers can help patients to know their rights and to self-advocate.

## 1-4 | Process Four: Ensure continuity of recovery process

Patients and families need ongoing support after leaving the hospital.

- Providers in the in-patient setting need to consider, as part of the recovery process, how to help patients solve the problems they may encounter upon discharge.
- Providers have to ensure the transition process from hospital to community is smooth and that recovery-oriented mental health services are delivered in an uninterrupted flow over time.

## SESSION TWO | The recovery competency framework

Based on the recovery enabling processes, we developed a recovery competency framework:

Enabling Process	Core Competencies
Process 1: Engaging with patients to reduce tensions	1. Competencies to reduce environmental level tensions
	2. Competencies to reduce personal level tensions
	3. Competencies to reduce providers' own tensions
Process 2: Providing individually tailored services	4. Competencies to set goals and planning and provide individually tailored services
	5. Competencies to engage patients in decision making and satisfy their needs
Process 3: Fostering recovery	6. Competencies to foster recovery: know best practices of recovery
	7. Competencies to promote and advocate recovery
Process 4: Transition	8. Competencies to ensure continuity of recovery process

The structure of the following presentation:

In the following pages, we will introduce the recovery competencies required for in-patient providers. The structure of the presentation is:

First, we will illustrate the challenges and critical tensions as we discussed in Chapter Two.

Second, we will propose what a recovery-oriented practice looks like.

Finally, the required competencies to overcome the challenges and achieve the purpose are presented.



Process 1: Engage with patients to reduce tensions	
Challenge	Required competency
<i>1. Engage with patients in creating an environment in which they feel safe, accepted, helped, and nurtured while also maintaining an ordered inpatient setting</i>	
Challenge 1. The environmental level tensions  <i>Critical tension: Patients perceive the in-patient environment as non-humanistic, inflexible, unsafe, and lacking in stimulation.</i>  a. non humanistic physical environment b. inflexible ward routines c. unsafe atmosphere d. lack of resources e. hierarchical power structure f. institutionalization	1. Competencies to reduce environmental tensions a. create a warm and vital physical environment b. create an environment in which patients' privacy is respected c. develop a flexible ward schedule and integrate balanced routine of self-care, productivity, and leisure activities. d. create a safe, supportive, and accepting atmosphere e. provide initial orientation of all in-patient services to patients and families f. involve community resources and support g. ensure that patients have access to updated and good quality activity resources h. be willing to share information, knowledge, responsibility, and power with patients and significant others i. control the environmental stimulation which is suitable for patients' current status

<b>Process 1: Engage with patients to reduce tensions</b>	
<b>2. Engage patients in equipping themselves with knowledge and skills to manage their health and well-being in their preferred ways</b>	
<p><b>Challenge 2. The personal level tensions</b></p> <p><i>Critical tension: Patients may be experiencing acute illness or other experiences of distress which prevents them from engaging in recovery planning.</i></p> <ul style="list-style-type: none"> <li>a. psychotic symptoms</li> <li>b. behavioral problems (intimidating, risky, or self-harmful behaviors)</li> <li>c. cognitive impairment</li> <li>d. emotional distress</li> <li>e. lack of motivation</li> <li>f. treatment-refractory illness</li> <li>g. side-effects of the medications</li> </ul>	<p><b>2. Competencies to reduce patients' inherent tensions</b></p> <ul style="list-style-type: none"> <li>a. integrate bio-psycho-social models of interventions through implementing evidence-based and best practices, such as psycho-pharmacotherapy, cognitive therapy, CBT, supportive therapy, reinforcement therapy, temporary controlling therapy, family psychoeducation, group therapy, activity health intervention ...</li> <li>b. apply motivational enhancement strategies</li> <li>c. understand patients and their stages of recovery</li> <li>d. provide patients with information</li> </ul>
<b>Process 1: Engage patients to reduce tensions</b>	
<b>3. Become a practitioner who believes in and is knowledgeable of recovery, and who is able to self-reflect and encourage changes</b>	
<p><b>Challenge 3. Providers' own tensions</b></p> <p><i>Critical tension: Providers may not demonstrate recovery attitudes, knowledge, skills, and behaviors in their daily practice.</i></p> <ul style="list-style-type: none"> <li>a. lack of recovery competencies (belief in medical model, non recovery-oriented attitude...)</li> <li>b. inability to transfer recovery knowledge to practice</li> <li>c. feelings of pressure, tension, and frustration as a result of patients' conditions, as well as apparent conflicts between human rights and some interventions</li> <li>d. lack of motivation to change</li> <li>e. lack of colleague support</li> <li>f. providers' own beliefs toward patients with serious mental illness</li> </ul>	<p><b>3. Competencies to reduce providers' own tensions</b></p> <ul style="list-style-type: none"> <li>a. demonstrate recovery attitudes/beliefs (respect, empathy, inclusion, client-centeredness, focus on strengths...)</li> <li>b. demonstrate a holistic understanding of recovery knowledge: dimensions and stages of recovery, the meaning of recovery for all stakeholders, models of services delivery, discrimination and stigma issues, transfer of knowledge to practice</li> <li>c. be able to build collaborative and trustful relationships with patients and their significant others</li> <li>d. practice in the role of recovery guide, coach, mentor, and facilitator</li> <li>e. be able to self-reflect</li> <li>f. use understandable, respectful, and empowering verbal and body language</li> <li>g. advocate recovery within the in-patient teams</li> <li>h. be able to resolve conflicts or issues raised in recovery-oriented services, and facilitate interdisciplinary communication</li> <li>i. convey attitude of active respect and dignity for patients' rights and freedoms in all environments</li> </ul>



<b>Process 2: Provide individually tailored services</b>	
<p>4. Engage patients as collaborators in setting their own goals and planning, and help them work toward these goals</p>	
<p><b>Challenge 4. Setting goals and planning and providing individually tailored services</b></p> <p><i>Critical tension: Intervention and decision making are based on the medical model. Patients are not empowered to take responsibility.</i></p> <ul style="list-style-type: none"> <li>a. significant others don't support recovery; stakeholders' goals are different</li> <li>b. patients insist on goals that appear unrealistic /unfeasible</li> <li>c. patients depend on hospital care and don't appear to move forward</li> <li>d. time challenge 1- high turnovers of patients; Not have enough time to implement recovery planning</li> <li>e. time challenge 2- practitioners' time constraints. Practitioners do not have enough time to offer time-consuming services or cannot satisfy different patients' needs at the same time</li> </ul>	<p><b>4. Competencies to set goals and planning with patients and provide individually tailored services</b></p> <ul style="list-style-type: none"> <li>a. demonstrate a holistic understanding of patients by assessing people and their context objectively</li> <li>b. interpret perceived deficits within a strengths and resiliencies framework</li> <li>c. effectively communicate with patients and their significant others</li> <li>d. incorporate all stakeholders' goals and involve them in decision making</li> <li>e. educate significant others and involve them in in-patient interventions and approaches</li> <li>f. help patients reframe situations and plan concrete next steps, along with specific timelines</li> <li>g. set individual recovery outcome indicators</li> <li>h. prioritize patients' goals and needs</li> <li>i. develop and lead groups which are organized to meet individualized goals for each patient</li> </ul>
<b>Process 2: Provide individually tailored services</b>	
<p>5. Address the unique needs of patients and find the balance between respecting patients' choices and maintaining ward structure through negotiation of positive risk taking</p>	
<p><b>Challenge 5. Provide choices based on individual needs</b></p> <p><i>Critical tension: It is difficult to address different patients' needs in a restricted environment.</i></p> <ul style="list-style-type: none"> <li>a. tensions exist between patients' needs/rights/choices and the structure of the units</li> <li>b. patients' decisions may lead to harmful/negative outcomes</li> </ul>	<p><b>5. Competencies to engage patients in decision making and satisfy their needs</b></p> <ul style="list-style-type: none"> <li>a. demonstrate an understanding of patients' experiences and be able to negotiate the dilemmas between patients' choices and the ward structure</li> <li>b. promote safety and positive risk taking</li> <li>c. help people articulate their needs and concerns</li> <li>d. provide a wide range of options, activities, and education according to patients' needs and current stages of recovery</li> <li>e. encourage patients to make choices and help them through the decision-making process</li> <li>f. engage patients at their own pace</li> <li>g. support patients through interim setbacks after they choose to take risks</li> </ul>

<b>Process 3: Foster recovery</b>	
<i>6. Foster the positive cycle of hope, empowerment, meaningful life, and personal growth</i>	
<p><b>Challenge 6. Foster a positive recovery cycle</b></p> <p><i>Critical tension: patients can be in a negative cycle of hopelessness, powerlessness, vulnerability, and repeated relapse.</i></p> <p>a. patients can be extremely fragile/have extremely low self-esteem</p>	<p><b>6. Competencies to foster recovery: know best practice of recovery</b></p> <p>a. <b>Hope instillation:</b>  *help patients and people around them develop or restore hope  *convey to patients an understanding of the context of the illness  *help patients find meaning in their lives  *help patients achieve successful experiences  *provide spiritual care</p> <p>b. <b>Empowerment:</b>  *know and apply strategies to empower patients  *help patients build confidence and positive self-identity  *encourage patients to make meaningful contributions to their own recovery</p> <p>c. <b>Strengths and skills building:</b> enable patients to find their strengths, learn illness/crisis/behavioral management and prevention skills, coping skills, living skills, social skills..</p> <p>d. <b>Network building:</b>  * help patients build and maintain more connections, relationships, and resources  *connect with the community</p> <p>e. <b>Readiness in recovery:</b> prepare patients to be ready for their next steps of the recovery processes</p>
<b>Process 3: Foster recovery</b>	
<i>7. Take a proactive role in diminishing stigma and promoting recovery in the community</i>	
<p><b>Challenge 7. Promoting recovery and advocacy</b></p> <p><i>Critical tension: Existing stigmas prevent patients from moving forward.</i></p> <p>a. patients' internalized stigma  b. social stigma</p>	<p><b>7. Competencies to promote and advocate recovery</b></p> <p>a. help patients self-advocated and know their rights  b. involve peer-provided services in in-patient settings  c. facilitate patients' access to self-help groups and peer-support groups  d. take a proactive role in reducing stigma, for example, participating in public education, portraying mental illness in a respectful and hopeful way</p>
<b>Process 4: Transition</b>	
<i>8. Connect patients and significant others to community services and resources they need</i>	
<p><b>Challenge 8. Provide transitional services</b></p> <p><i>Critical tension: Moving from the in-patient to community environment can be a complex transition. In-patients may not have access to supports to connect them to resources and opportunities in the community.</i></p> <p>a. insufficient resources and ongoing support in the community</p>	<p><b>8. Competencies to ensure continuity of care</b></p> <p>a. connect patients to their most significant healing relationships and supports  b. anticipate potential problems/issues in making community connections and strategize supports accordingly  c. help people solve the problems with their transition planning – finance, housing, relationships, resources ...  d. integrate community resources and connect to patients and significant others  e. strengthen partnership with local community services and help patients with transitional processes (referral or follow-up)</p>

### **Let's review the Recovery Competency Framework again**

- The in-patient setting features more environmental restrictions than other mental health services settings. In-patient provider competencies have to incorporate specific considerations of environmental design.
- Some unique differences based on the in-patient context are highlighted specifically in this competency framework. This competency framework has a unique contribution to address specific needs of in-patient providers.

### **Self-reflection exercise**

After reading the recovery competency framework, let's do another self-reflection exercise.

The following shows "Ten Top Tips for recovery oriented practice" (retrieved from: [www.centreformentalhealth.org.uk/pdfs/recovery\\_http://toptips.pdf](http://www.centreformentalhealth.org.uk/pdfs/recovery_http://toptips.pdf))

### **After each interaction with your patients, ask yourself did I...**

1. actively listen to help the person make sense of their mental health problems?
2. help the person identify and prioritise their personal goals for recovery – not my professional goals?
3. demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?
4. identify examples from my own 'lived experience', or that of other service users, which inspires and validates their hopes?
5. pay particular attention to the importance of goals which take the person out of the 'sick role' and enable them actively to contribute to the lives of others?
6. identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of their goals?
7. encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)?
8. discuss what the person wants in terms of therapeutic interventions, e.g. psychological treatments, alternative therapies, joint crisis planning, etc., respecting their wishes wherever possible?

9. behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to ‘go the extra mile’?
10. while accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations?

---

**Quiz:** *Providing in-patients with choices is:*

- A. not appropriate because most patients are too disabled to make good decision*
- B. a principle used in community mental health rehabilitation*
- C. a way to help patients understand themselves*
- D. only allowed once a patient is recovered*

*Correct answer: C (Answer C is correct because the more choices patients make for themselves, the easier they get to know themselves. Making choices is also a way of learning. Making choice is allowed at any stages of recovery)*

---

**Quiz:** *Which of the following actions may hinder people’s recovery?*

- A. Answer people’s questions in a timely manner*
- B. Help people figure out how to make their plans work*
- C. Reminding people of their strengths*
- D. Viewing people through the lens of diagnosis*

*Correct answer: D (We should view the person him/herself instead of the label of diagnosis.)*

---

**Quiz:** *A recovery-based service plan includes which of the following points:*

- A. Families know the best interest of the person*
- B. All treatment team members make the decision together because they know the person best*
- C. The person takes the lead*
- D. A service plan should be built on the foundation of problem-solving*

*Correct answer: C (The person knows the best interest of him/herself and should take the lead in the service planning. A service plan should be built on the foundation of hope and strengths.)*

## CLOSING

Thank you so much for participating in the Recovery Self-Learning program. We are so glad to share what we have learned about recovery with you.

We have three hopes ...

*- Hope this learning experience is relevant and useful to your work and can help you gain a better understanding of recovery.*

*- Hope you will be able to apply the recovery knowledge in your daily practice.*

*- Hope you will promote recovery-oriented services in your unit.*

*Thank You!*

## Appendices

### 1 | Recovery measurement (volume I)

Ralph, R. O., Kidder, K., & Phillips, D. (2000). Can we measure recovery? A compendium of recovery and recovery-related instruments.

You can access this article by: [http://www.tecathsri.org/pub\\_pickup/pn/pn-43.pdf](http://www.tecathsri.org/pub_pickup/pn/pn-43.pdf)

The title page and the table of contents are showed in the next pages.

## Can We Measure Recovery?

*A Compendium of Recovery and  
Recovery-Related Instruments*



June 2000

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[www.samhsa.gov](http://www.samhsa.gov)

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## 2 | Recovery measurement (Volume II)

Campbell-Orde, T., Camberlin, J., Carpenter, J., & Leff, H. S. (2005). Measuring the promise: A compendium of recovery measures, Volume II.

You can access this article by: <http://www.power2u.org/downloads/pn-55.pdf>

The title page and the table of contents are showed in the next pages.

*Measuring the Promise:  
A Compendium of Recovery  
Measures*

*Volume II*



September 2005

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## References

- Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry*, 37(5), 586–594.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11-23.
- Anthony, W. A. (2000). A recovery-oriented service system: Setting some system-level standards. *Psychiatric Rehabilitation Journal*, 23, 159-168.
- Brown, W., & Kandirikirira, N. (2007). Engagement. In: *Recovering mental health in Scotland. Report on narrative investigation of mental health recovery*. Glasgow, Scottish Recovery Network. Accessed from [www.scottishrecovery.net/content/default.asp?page=s5\\_4](http://www.scottishrecovery.net/content/default.asp?page=s5_4)
- Chen, S-P., Krupa, T., Lysaght, R., McCay, E., & Piat, M. (2011). The development of recovery competencies for in-patient mental health providers working with people with serious mental illness, *Administration and Policy in Mental Health and Mental Health Services Research*, Oct 19, 2011, DOI: 10.1007/s10488-011-0380-x
- Corrigan, P. W., Giffort, D., Rashid, F., Leary, M., & Okeke, I. (1999). Recovery as a psychological construct. *Community Mental Health Journal*, 35, 231-239.
- Corrigan, P. W., Salzer, M., Ralph, R. O., Sangster, Y., & Keck, L. (2004). Examining the factor structure of the Recovery Assessment Scale. *Schizophrenia Bulletin*, 30, 1035-1041.
- Cunningham, K., Wolbert, R., Graziano, A., & Slocum, J. (2005). Acceptance and change: The dialectic of recovery. *Psychiatric Rehabilitation Journal*, 29, 146-148.
- Cutcliffe, J. R., & Hannigan, B. (2001). Mass media, "monsters" and mental health clients: The need for increased lobbying. *Journal of Psychiatric and Mental Health Nursing*, 8, 315-321.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16, 459-470.

- Davidson, L., & Strauss, J.S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, 65, 131-145.
- Davidson, L., Tondora, J., Lawless, M. S., O'Connell, M. J., & Rowe, M. (2009). *A practical guide to recovery-oriented practice: Tools for transforming mental health care*. (chap 2). New York, NY: Oxford University Press, Inc.
- Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11, 11-19.
- Deegan, P. E. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing and Mental Health Services*, 31, 7-11.
- Deegan, P. E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19, 91-97.
- Deegan, P. E. (2001). Recovery as a self-directed process of healing and transformation. *Occupational Therapy in Mental Health*, 17, 5-21.
- Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41, 141-158.
- Felton, B. J., Barr, A., & Clark, G. (2006). ACT team members' responses to training in recovery-oriented practice. *Psychiatric Rehabilitation Journal*, 30, 112-119.
- Fisher, D., & Chamberlin, J. (2004). *A consumer/survivor led transformation of today's institutionally-based system to tomorrow's recovery-based system*. Lawrence, MA: National Empowerment Center.
- Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 248-256.
- Lieberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, 14, 256-272.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, 23, 333-341.



- Krupa, T. (2004). Employment, recovery, and schizophrenia: Integrating health and disorder at work. *Psychiatric Rehabilitation Journal*, 28, 8-15.
- Lieberman, R. P. (2002). Future directions for research studies and clinical work on recovery from schizophrenia: Questions with some answers. *International Review of Psychiatry*, 14, 337-342.
- Mead, S., & Copeland, M. E. (2000). What recovery means to us: Consumer's perspectives. *Community Health Journal*, 36, 315-328.
- Merryman, M. B., & Riegel, S. K. (2007). The recovery process and people with serious mental illness living in the community: An occupational therapy perspective. *Occupational therapy in Mental Health*, 23, 51-73.
- NHS Education for Scotland. (2008). *Realising recovery: learning materials*. Retrieved February 24, 2010, from SCOTTISH RECOVERY NETWORK:  
<http://www.nes.scot.nhs.uk/mentalhealth/publications/documents/13875-NES-MentalHealth-Allmodules.pdf>
- Noordsy, D., Torrey, W., Mueser, K., Mead, S., O'Keefe, C., & Fox, L. (2002). Recovery from severe mental illness: An intrapersonal and functional outcome definition. *International Review of Psychiatry*, 14, 318-326.
- O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers*. Retrieved March 9, 2011 from  
[http://www.maryohagan.com/resources/Text\\_Files/Recovery%20Cometencies%20O'Hagan.pdf](http://www.maryohagan.com/resources/Text_Files/Recovery%20Cometencies%20O'Hagan.pdf)
- O'Hagan, M. (2004). Recovery in New Zealand: Lessons for Australia? *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 3, Retrieved March 9, 2011 from  
<http://www.familymentalhealthrecovery.org/conference/handouts/Workshop%2010/OHagan%201%20Recovery%20in%20NZ.pdf>
- Ontario Ministry of Health & Long-Term Care. (1999). *Making It Happen: Implementation Plan for Mental Health Reform*. Retrieved February 21, 2011, from:  
[http://www.health.gov.on.ca/english/public/program/mentalhealth/mental\\_reform/makingithappen\\_mn.html](http://www.health.gov.on.ca/english/public/program/mentalhealth/mental_reform/makingithappen_mn.html)

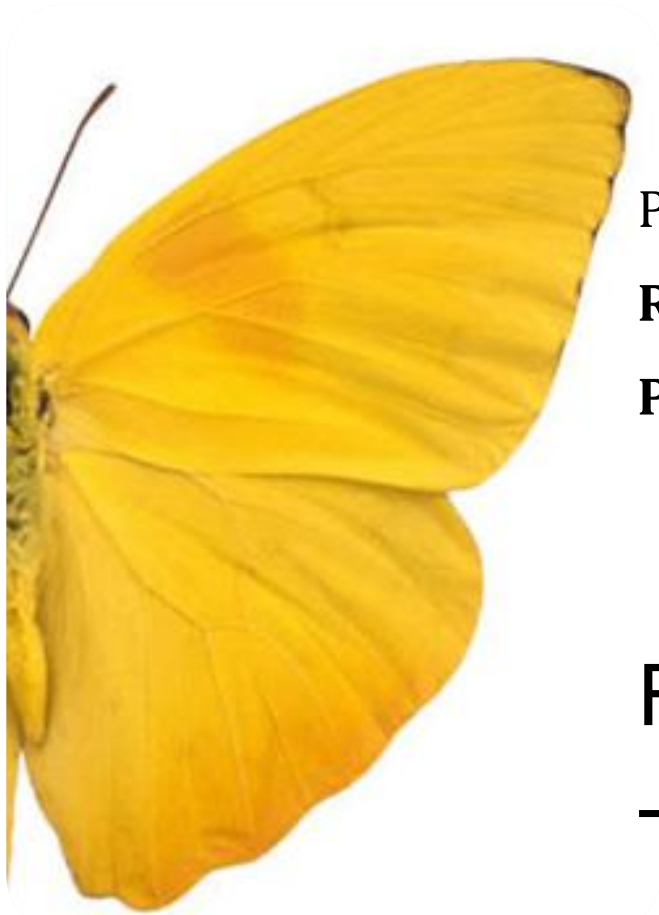
- Pettie, D., & Triolo, A. M. (1999). Illness as evolution: The search for identity and meaning in the recovery process. *Psychiatric Rehabilitation Journal*, 22, 255-262.
- Piat, M., Sabetti, J., & Bloom, D. (2010). The transformation of mental health services to a recovery-oriented system of care: Canadian decision maker perspectives. *International Journal of Social Psychiatry*, 56, 168-177.
- Provencher, H. L., Gregg, R., Mead, S., & Mueser, K. T. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 26, 132-144.
- Ragins, M. (2008). Recovery with severe mental illness: Changing from a medical model to a psychosocial rehabilitation model. Retrieved October 24, 2008, from Mental Health America of Los Angeles: The Village Integrated Service Agency: <http://www.village-isa.org/Ragin's%20Papers/recov.%20with%20severe%20MI.htm>
- Ralph, R. O. (2000). Review of recovery literature: A synthesis of a sample of recovery literature 2000. Retrieved October 24, 2008, from National Association of State Mental Health Program Directors (NASMHPD): [http://www.nasmhpd.org/general\\_files/publications/ntac\\_pubs/reports/ralphrecovweb.pdf](http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/ralphrecovweb.pdf)
- Ralph, R., Lambric, T., & Steele, R. (1996). Recovery issues in a consumer developed evaluation of the mental health system. Paper presented at the 6th Annual Conference on State Mental Health Agency Services Research and Program Evaluation, Arlington, VA.
- Repper, J. M. (2000). Adjusting the focus of mental health nursing: Incorporating service users' experiences of recovery. *Journal of Mental Health*, 9, 575-587.
- Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. London, UK: Bailliere Tindall.
- Resnick, S. G., Fontana, A., Lehman, A. F., & Rosenheck, R. A. (2004). An empirical conceptualization of the recovery orientation. *Schizophrenia Research*, 72, 119-128.
- Resnick, S.G., Fontana, A., Lehman, A.F., & Rosenheck, R.A. (2005). An empirical conceptualization of the recovery orientation. *Schizophrenia Research*, 75, 119–128.

- Rickwood, D. (2004). Recovery in Australia: Slowly but surely. *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, 3, [www.auseinet.com/journal/vol3iss1/rickwoodeditorial.pdf](http://www.auseinet.com/journal/vol3iss1/rickwoodeditorial.pdf)
- Ridgway P. (2001). Restorying psychiatric disability: learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 335-343.
- Rodgers, M. L., Norell, D. M., Roll, J.M., & Dyck, D, G, (2007). An overview of mental Health recovery. *Primary Psychiatry*, 14, 76-85.
- Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. New York, NY: Cambridge University Press.
- Smith, M. K. (2000). Recovery from a severe psychiatric disability: findings of a qualitative study. *Psychiatric Rehabilitation Journal*, 24, 149-158.
- Spaniol, L. (2001). Recovery from psychiatric disability: Implications for rehabilitation Counseling education. *Rehabilitation Education*, 15, 167-175.
- Spaniol, L., Koehler, M., & Hutchinson, D. (1994). *Leader's Guide: The Recovery Workbook*. Boston, MA: Boston University, Center for Psychiatric Rehabilitation.
- Spaniol, L., Wewiorski, N. J., Gangne, C., & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry*, 14, 327-336.
- Stickley, T., & Felton, A. (2006). Promoting recovery through therapeutic risk-taking. *Mental Health Practice*, 9, 26-30.
- The Standing Senate Committee on Social Affairs, Science and Technology (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Section 3.2, ¶ 3. Retrieved March 18, 2008, from <http://www2.parl.gc.ca/ParLIgner/Highlighter.aspx?Query=mental+health+recovery&lang=e&url=http%3a%2f%2fwww.parl.gc.ca%2f39%2f1%2fparlbus%2fcommbus%2fsenate%2fcome%2fsoci-e%2frep-e%2frep02may06part1-e.htm>
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2006). *National consensus statement on mental health recovery*. Retrieved Feb. 2, 2008, from <http://www.samhsa.gov>.

- Torgalsbøen, A-K. (2005). What is recovery from schizophrenia? In L. Davidson, C. Harding, & L. Spaniol, *Recovery from severe mental illness: Research evidence and implications for practice, Volume 1* (pp. 302-315). Boston, MA: The Center for Psychiatric Rehabilitation.
- WHO. (2001). International Classification of Functioning, Disability and Health: ICF. (p.242). Geneva, Switzerland: World Health Organization.
- Young, S. L., & Ensing, D. S. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal*, 22, 219-231.

## **4.4.2 Part Two: Group learning Program**

### 4.4.2.1 Facilitator's Toolkit



**PART TWO**  
**RECOVERY GROUP-LEARNING**  
**PROGRAM**

**FACILITATOR'S**  
**TOOLKIT**



by

Shu-Ping Chen  
Terry Krupa  
February, 2011

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## INTRODUCTION

Part Two of the recovery learning program consists of two learning modules which focus on two real-life dilemmas experienced in in-patient settings and applies the appreciative inquiry approach to address these dilemmas. The toolkit provides guidance and resources for facilitators to deliver these two learning modules, which have been designed for use by providers who have completed the first part of the recovery learning program.

Participative group dialogue and actions are preferred methods for delivery of these two learning modules. Learning will be enhanced through implementation and reflection on the changing process discussed in the group. There are three group learning sessions in each learning module. This Toolkit provides guidance on how to deliver the learning materials as a facilitated group and also signposts some methods of facilitating the learning. The facilitator can follow the guideline through Group One to Group Three. Resources for delivery are appended at the end of the Toolkit. If you have any questions, please contact Shu-Ping Chen at [6sc56@queensu.ca](mailto:6sc56@queensu.ca) or 613-541-1623.

### 1 | The participants

Part Two of the Recovery learning package is delivered to participants who have completed Part One. The recommended number of participants in a group is 3-10 with one facilitator to deliver the training. A co-facilitator is recommended but optional. The role of a co-facilitator could be taking notes during group sessions and facilitating members' participation in the group. Learning will be enhanced if participants from different disciplines can join together to provide interdisciplinary perspectives.

### 2 | Time

The approximate time to complete a learning module is 3 weeks. There are 3 group learning sessions required in a learning module. One group learning session per week is recommended:



First group session (at the beginning of 1<sup>st</sup> week; 90 minutes): Discovery & Dreaming

1. Explore positive perspectives and share peak experiences
2. Challenge the current status by envisioning a more positive future

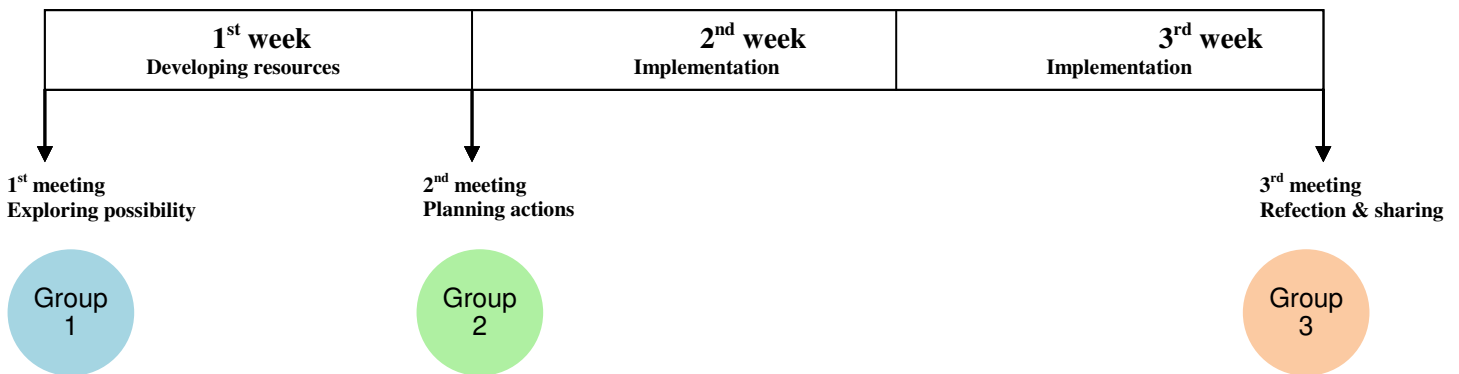
Second group session (at the beginning of 2<sup>nd</sup> week; 90 minutes): Designing & Delivery

1. Use the data gathered through the discovery and dreaming phases to co-construct the action plans toward the vision
2. Plan the feasible action plans
3. Implement the action plans

Third group session (at the end of 3<sup>rd</sup> week; 90 minutes): Destiny & Reflection

1. Reflect on and learn from the actions
2. Share the transformative experience

See the following figure for the recommended time schedule. Each meeting may last for 90 minutes.



### 3 | Setting up the learning group

1. Actively engage potential participants in the group learning program:

- \* Secure their interest in participation, for example, as a required education in the unit.

2. Set up the time for three group learning sessions with the participants who agree to join the learning group.
3. Arrange the place for the group sessions.
4. Send detailed information to the participants, including time and place for the meetings.

## MODULE 1: Encouraging participation

This learning module focuses on the dilemma of encouraging patients' participation in activities.

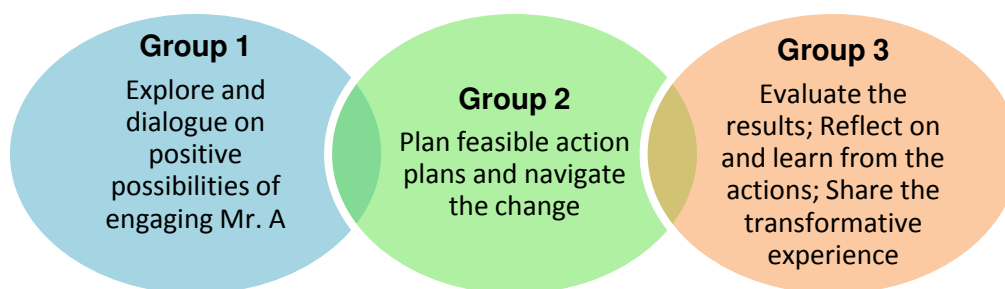
### 1 | Case scenario

Mr. A, a 38-year-old man, was admitted two weeks ago to the in-patient ward having taken an overdose of sleeping tablets, while experiencing recurrent psychotic symptoms. Mr. A has a history of repeated psychotic episodes starting in his early 20s. Most of the time, his symptoms remained under control and he was able to function well in the community. He was unemployed. Before admission, Mr. A was isolated, staying in much of the night to do crossword puzzles. He has not been in touch with his friends since his admission as he does not want them to know about his mental illness.

Mr. A spends most of his time on the ward sleeping. Every morning when it's time to get up for breakfast, self-care, and making his bed, Mr. A does not want to do anything. He tells providers that he would like to stay in bed all day; he does not need to take a shower and get dressed. The ward staff have given him information about the activities available to him, but he states he is not interested. All he wants is to be left alone and allowed to go home.

*Staff dilemma: If Mr. A doesn't want to do anything or if he wants to stay in bed, that's his choice. However, as a provider, engaging him is my obligation since it can positively influence his health. I am not strict but there are some things that he has to do such as personal care. How can I engage Mr. A in activities to enable his recovery?*

## 2 | Purpose



### SESSION 1.1 | The first group session

#### 1 | Planning group 1

Facilitator	
Co-facilitator (Optional)	
Participants	
Date and Time	
Venue	
Objectives	<ol style="list-style-type: none"><li>1. Clarify values, share peak experiences</li><li>2. Explore and dialogue on positive possibilities</li><li>3. Challenge the current status by envisioning more positive future</li></ol>
Materials required	Voice recorder, Flip chart/markers

1. Prepare to introduce the Appreciative Inquiry Approach

---

*See [Resource A: Appreciative inquiry approach and the group design](#) (page 226)*

2. Prepare to explain the case scenario

## 2 | Group agenda

### 1. Introduction & Warm-up (20 minutes)

a. Brief the group regarding the appreciative inquiry approach and the purpose of the three group meetings; then focus on the objectives of today's group

b. Participants introduce themselves and their expectations of the group

c. Warm-up activity:

Guide the participants' thinking about this issue and have a brief sharing:

“Based on your recovery knowledge and/or reflections on Part One of the learning package, please describe one example of recovery-oriented practice in the unit”.

d. Explain the case scenario: Mr. A

\* Do you have any questions about this case scenario?

\* Have you experienced similar situation?

\* Facilitate participants' discuss of the case scenario and dilemma.

### 2. Questions & discussion (60 minutes)

#### Discovery Phase

a. Ask the participants to describe an experience when they successfully engaged a patient in an activity.

“I would like you to think about a time when, as a staff in this unit, you had an exceptional experience – when you successfully engaged a patient who did not appear engageable; when you were most proud of being here doing this work. You knew that you were making a difference in the lives of people you were serving. Think back and tell the group members this experience.”

- Probing questions:

- \* What did you do to make this experience happen?
- \* Who else contributed to it?
- \* What was it about the patient that made this happen?
- \* What did you appreciate about the experience? What did you most value about the service you provided?
- \* If you could make three wishes for your unit so that you could have more of these exceptional experiences, what would they be?

b. Ask the participants to reframe this case scenario into positives.

- You can provide the participants the following hints:

- \* Help the participants understand Mr. A’s behaviors and how to engage him at his own pace
- \* Ask them “What are Mr. A’s strengths?”
- \* Ask them “What are Mr. A’s needs?”

*Dreaming Phase – developing a vision for the future of the program*

a. Ask the participants to imagine that they successfully engaged a patient to participate in activities.

- \* What might those activities be on a daily basis?
- \* What could they do that is different from what they are doing now?
- \* What steps would he/she need to take?
- \* What resources would he/she need?

b. Ask the participants: “Imagine that it is one year from now. You are preparing for a presentation at a forum in this hospital that will share the successful story of the recovery-oriented program in your unit.

You are quite proud to be the representative of your program. After the presentation, the audiences ask you the following questions. What are your answers?”

- \* What are the major changes inside your unit?
- \* What factors have made this success possible and exemplary?
- \* What is happening that makes you proud?

### 3. Closing (10 minutes)

- a. Reflection on today’s discussion.
- b. The co-facilitator will send the group notes to all participants. The participants will be asked to think about the action plans, collect related resources, and bring their ideas to the next group.

---

***Reminder:** Even when providers bring up problems, guide their attention to what worked in seeming problematic situations, guide them to appreciate the problem.*

---

***Reminder:** (if applicable) The co-facilitator takes notes for the group discussion and sends the notes to all participants. If there is no co-facilitator, the facilitator takes a brief summary of the group discussion and sends the summary to the participants.*

## SESSION 1.2 | The second group session

### 1 | Planning group 2

Facilitator	
Co-facilitator (Optional)	
Participants	
Date and Time	
Venue	
Objectives	1. Use the data gathered through the discovery and dreaming phases to co-construct the action plans toward the vision 2. Plan the feasible action plans and navigate the change
Materials	Voice recorder; Flip chart/markers; the management plan poster; a sharing board

1. Organize the first group notes and send them to the participants
2. Collect resources
3. Draw a table showing the management plan on a poster

*See [Resource B: Management Plan Table & Examples](#) (page 230)*



## 2 | Group agenda

### 1. Introduction & Warm-up (15 minutes)

- a. Summarize the discussion at the last group session and introduce the objectives of today's group
- b. Review case scenario Mr. A
- c. Warm-up: Show a short video (How to engage participation)

### 2. Group Discussion (65 minutes)

#### Designing Phase

- a. Ask the participants: "How might you engage with Mr. A in a way that would inspire hope?"
  - Although Mr. A may be in a fairly hopeless frame of mind, there is one desire he has that could be built on and worked with: his wish to leave hospital. This suggests that this patient has some sense of future. Providers can help Mr. A identify what he needs to do to secure his discharge, and then hope may be maximized.
- b. Ask the participants: "What aspects of the life is Mr. A able to control within the in-patient setting?"
  - The starting point might be to discuss with the patient the areas in which he still has choices and control.
  - Think about the characteristics of the unit
- c. Ask the participants: "What are possible enablers that can facilitate Mr. A's participation in activities?"
  - Personal enablers
  - Environmental enablers

d. Ask the participants: “If you could transform the ways in which you engage Mr. A, what would it look like and what would it take to happen?”

- You can provide the participants the following hints:

\* Think about designing a warm physical environment that encourages participation

Examples: have the patients participate in the design and decoration of the unit; have some decoration related to Mr. A’s interests.

\* How to provide options in the units?

\* How to build a collaborative and trustful relationship with Mr. A

\* Apply motivational enhancement strategies

\* List five small steps that would have the greatest impacts

e. Seek possible support and resources with the participants.

- At the individual level: What are Mr. A’s personal support or resources?

- At the program level: What are the support or resources which our program can provide with Mr. A?

- At the system level: What are the support or resources which the mental health system can provide with Mr. A?

Delivery Phase: Let’s think together about some first steps to engage in-patients.

1. Think about yourself, your unit, and your hospital, what are some things that you can do tomorrow?

2. What are some things that we can do in the next two weeks?

3. Develop a management plan that helps keep the actions on time and on track.

*(see examples at page 230 to help guide the work)*

Action Plans	The person in charge	Timeline	Indicators	Data collection methods
1.				
2.				
3.				
4.				
5.				

### 3. Closing (10 minutes)

1. The participants commit to making all the action plans happen in the next two weeks.
  
  2. Set up a sharing board in this room. Ask the participants to share their actions and support with each other frequently on this board in the next two weeks.
- \* The co-facilitator/facilitator will send the group notes/summary to all participants.

*Tip: The facilitator can post a big management plan poster in this room for the participants to track the progress of the action plans.*

## SESSION 1.3 | The third group session

### 1 | Follow up the implementation of the action plans

Now, the participants have the opportunity to implement the action plans that have been developed in the second meeting. Keep track of the action plans using this recommended table:

Action Plans	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
1.								
2.								
3.								
4.								
5.								

*(see page 230 for examples)*

## 2 | Planning group 3

Facilitator	
Co-facilitator (Optional)	
Participants	
Date and Time	
Venue	
Objectives	<ol style="list-style-type: none"><li>1. Monitor progress</li><li>2. Evaluate the results</li><li>3. Reflect on and learn from the actions</li><li>4. Share the transformative experience</li></ol>
Materials	Voice recorder; Flip chart/markers; the management plan poster; the sharing board; a cake

1. Record the results and finish the management plan poster
2. Summarize the participants' sharing content on the sharing board
3. Organize the celebration of the group's success (maybe a cake or some dessert)

## 3 | Group agenda

### 1. Introduction & Warm-up (20 minutes)

- a. Summarize the action plans discussed at the second meeting, appreciate every participant's efforts, and introduce the objectives of today's group

b. Warm-up:

Go around the room and have each participant complete the sentence:

“The best thing, in relation to recovery, that I did in the past two weeks was ...”

c. Each person in charge of the action plans presents their results

**2. Group Discussion (40 minutes)**

*Destiny & Reflection Phase*

a. Reflection on the learning experience. Ask the participants to describe the actions they implemented in the past two weeks.

- How did these actions work out?

b. What were the successes?

c. What needs to be further modified or improved?

d. What did you learn that will help or sustain the change?

b. Ask the participants: “How can we share this learning experience with other staff?”

c. Ask the participants: “Can we take one idea in the group and implement this idea across the whole unit?” – Discuss the details.

d. Plan “what’s next”?

a. What do you like about the things you did?

b. What would you add to make the process stronger?

c. What will inspire ongoing actions?

**3. Closing (30 minutes)**

a. Have a celebration of success & thanks for everybody’s endeavor

b. Announce the time and place of the Learning Module 2.

## MODULE 2: Strength-based practice

### 1 | Participants

The second learning module is delivered to participants who have completed Part One of the self-learning package, but is not limited to those who have completed the first group learning module. The recommended number of participants in a group is 3-10 with one facilitator to deliver the training. A co-facilitator is recommended but optional.

*Tip: The facilitator actively engages all participants who have completed learning module 1 for participation in learning module 2. If someone cannot continue participation, help him/her remove barriers to participation if possible.*

*Tip: Inform the unit that the group welcomes any new member who is interested in the group learning, contact the potential new participants, and secure their participation*

### 2 | Preparation

- a. Set up the time for three group learning sessions with the participants who agree to join Learning Module 2.
- b. Arrange the place for the group sessions.
- c. Send detailed information to the participants, including time and place for the meetings.

### 3 | Case scenario

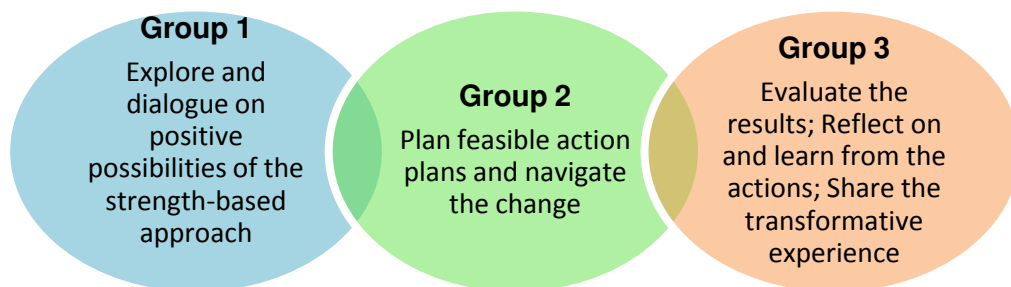
Two providers received hospital funding to attend a national conference focusing on recovery-oriented mental health services. The topic of discussion at the conference was strength-based mental health services. The providers were responsible for bringing back their new learning about recovery and sharing strength-based concepts with their colleagues.

The providers want to connect the structure of the team with the strength-based practice to see if the team can implement some of the ideas. They decide to start at the multidisciplinary team meeting which is held regularly to plan care and treatment.

However, the regular team meeting would be: Nursing staff gave a rapid account of a patient's presentation over the last couple days. Other team members might express information about the patient's psychosocial, family, or behavioral problems. Then the psychiatrist would express his/her opinion on the medical treatment. Different disciplines appear to share a common language in the conceptualizing of problems. Finally, a treatment plan might be developed in order to solve the problems.

Based on current structure of the team meeting, these two providers wondered how the strength-based approach can be applied by their team and what the best way is to introduce a different perspective which has not routinely been used.

### 4 | Purpose





## SESSION 2.1 | The first group session

### 1 | Planning group 1

Facilitator	
Co-facilitator (Optional)	
Participants	
Date and Time	
Venue	
Objectives	1. Clarify values, share peak experiences 2. Explore and dialogue on positive possibilities 3. Challenge the current status by envisioning more positive future
Materials required	Voice recorder, Flip chart/markers

1. If there are new participants, prepare a brief introduction of Appreciative inquiry approach and the group design.

2. Prepare to explain the case scenario

3. Prepare to explain “Strength-based approach”:

Based-on a problem-solving model, providers usually focus on “what is wrong with patients” and have had a tendency to overlook patients’ assets, strengths, and competencies. Also, the in-patient setting is not a natural life context where strengths can naturally emerge and be observed. The strength-based perspective encourages providers to recognize that, despite the presence of significant disability, patients

continue to have strengths and capabilities as well as the potential to learn (Davidson, et al, 2009). The strength-based approach may consist of the following practices:

- a. Identify patients' strengths: For example, strengths can broadly include: 1) skills and knowledge; 2) talents; 3) personal traits such as insight, patience, or self-discipline; 4) interpersonal skills; 5) previous experiences or accomplishments; 6) family support; 7) environmental resources such as a good boss, support network, service system, or community; and 8) spirituality, hopes, and dreams.
- b. Build upon patients' strengths: provide assistance for patients in acquiring knowledge/skills to attain their goals
- c. Use patients' strengths as resources to develop their recovery planning
- d. Help patients transfer their strengths to the natural environment

## 2 | Group agenda

### 1. Introduction & Warm-up (20 minutes)

- a. Brief participants about the appreciative inquiry approach (if there is any new members who did not attend the first learning module) and the purpose of the three group meetings; then focus on the objectives of today's group
- b. Participants introduce themselves and their expectations of the group
- c. Warm-up activity:

Get the participants thinking about this issue and have a brief sharing:

The issue is: "In the in-patient setting negatives/problems of people served often seem more important than their strengths. The positive perspective is easier to be neglected". Now, let's practice thinking positively.

→ The group thinks about a current patient in the unit and discusses this patient's strengths.

- d. Explain the case scenario and the strength-based approach:

\* Do you have any questions about this case scenario and the strength-based approach?

- \* Have you experienced situations that are similar or relevant to the case scenario?
- \* Let the participants discuss the case scenario and name what the challenges are.

## **2. Questions & discussion (60 minutes)**

### Discovery Phase

a. Think of a time when you believe you operated from a strength-based approach with an in-patient:

- \* What did you do to make this experience happen?
- \* What did you appreciate about the experience?
- \* What did you most value about the service you provided?

b. Think of a time when your in-patient team operated from a strength-based approach:

- \* What did your team do to make this experience happen?
- \* Who and what else contributed to it?
- \* What did you appreciate about this experience?
- \* What did you most value about the service you provided?
- \* If you could make three wishes for your team so that you could have more of these exceptional experiences, what would they be?

### Dreaming Phase – developing a vision for the future of the program

a. Ask the participants to imagine that they successfully enabled the use of a strength-based approach in their team.

- \* What does this use of a strength-based approach look like at the team meeting?
- \* What would the team members do that is different from what they are doing now?
- \* What resources would they need?
- \* What are the major changes in your team?

\* What factors that have made this success possible?

### **3. Closing (10 minutes)**

- a. Reflection on today's discussion.
- b. The co-facilitator/facilitator will send the group notes to all participants. The participants will be asked to think about potential action plans of implementing a strength-based approach in the team, collect related resources, and bring their ideals to the next group.

***Reminder:** Even when providers bring up problems, guide their attention to what worked in seemingly problematic situations, guide them to appreciate the problem and use their knowledge and expertise to devise potential solutions.*

## SESSION 2.2 | The second group session

### 1 | Planning group 2

Facilitator	
Co-facilitator (Optional)	
Participants	
Date and Time	
Venue	
Objectives	1. Use the data gathered through the discovery and dreaming phases to co-construct the action plans toward the vision 2. Plan the feasible action plans and navigate the change
Materials	Voice recorder; Flip chart/markers; the management plan poster; a sharing board

1. Organize the first group notes and sent them to the participants
2. Collect resources
3. Draw a table showing the management plan on a poster

*See Resource B: Management Plan Table & Examples (page 230)*

## 2 | Group agenda

### 1. Introduction & Warm-up (15 minutes)

- a. Summarize the last group session and introduce the objectives of today's group
- b. Review the case scenario from last week
- c. Warm-up: Using the following table to practice a “strength-based team meeting. Facilitate the participants to discuss the procedure of a strength-based team meeting.

Our current team meeting procedure is ...	A strength-based team meeting procedure would be ...
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

### 2. Group Discussion (65 minutes)

#### Designing Phase

- a. Ask the participants: “How might we enable the team members to accept and apply the strength-based perspective as a shared value?”
  - How to fulfill the strength-based value in our workplace?
  - The starting point might be?
  - Aspects of the unit that could facilitate a strength-based approach?

b. Ask the participants: “What are possible enablers that can facilitate our team to adopt a strength-based approach?”

- Personal enablers

- Environmental enablers

c. Ask the participants: “If you could transform elements of your team meeting so that it operated from a strength-based approach, what would this look like?”

- List five small steps that would have the greatest impacts

Delivery Phase

1. Let’s think together about some first steps to introduce a strength-based perspective. What are some things that we can do tomorrow?

2. What are some things that we can do in next two weeks?

3. Develop a management plan that helps keep the actions on time and on track.

(see examples at page 230 to help guide the work)

Action Plans	The person in charge	Timeline	Indicators	Data collection methods
1.				
2.				
3				
4.				
5.				

### **3. Closing (10 minutes)**

1. The participants commit to making all the action plans happen in the next two weeks.
2. Set up a sharing board in this room. Ask the participants to share their actions and support each other frequently on this board in the next two weeks.

\* The co-facilitator/facilitator will send the group notes to all participants.



## SESSION 2.3 | The third group session

### 1 | Follow up the implementation of the action plans

Now, the participants have the opportunity to implement the action plans that have been developed in the second meeting. Keep track of the action plans using this recommended table:

Action Plans	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
1.								
2.								
3.								
4.								
5.								

*(see page 230 for examples)*

## 2 | Planning group 3

Facilitator	
Co-facilitator (Optional)	
Participants	
Date and Time	
Venue	
Objectives	<ol style="list-style-type: none"><li>1. Monitor progress</li><li>2. Evaluate the results</li><li>3. Reflect on and learn from the actions</li><li>4. Share the transformative experience</li></ol>
Materials	Voice recorder; Flip chart/markers; the management plan poster; the sharing board; a cake/dessert *post-test questionnaires

1. Record the results and finish the management plan poster
2. Summarize the participants' sharing content on the sharing board
3. Organize the celebration of the group's success (maybe a cake or some dessert)

### 3 | Group agenda

#### 1. Introduction & Warm-up (15 minutes)

a. Summarize the action plans discussed at the second meeting, recognize every participant's endeavor, and introduce the objectives of today's group

b. Warm-up:

Go around the room and have each participant complete the sentence:

“To apply a strength-based approach, I successfully (did something....) in the past two weeks”

c. Each person in charge of the action plans presents their results

#### 2. Group Discussion (45 minutes)

##### Destiny & Reflection Phase

a. Reflection on the learning experience. Ask the participants to describe the actions they did in the past two weeks to apply a strengths based approach.

a. How did these actions work out?

b. What were the successes?

c. What needs to be further modified or improved?

d. What did you learn that will help or sustain the change?

b. Ask the participants: “How can we share this learning experience with other staff on the unit?”

c. Ask the participants: “How can we enable other staff, who did not participate in the training, to implement the strength-based approach on their team/unit?” – Discuss the details.

d. Plan “what's next”?

a. What do you like about things you did?

b. What would you add to make the process stronger?

c. What will inspire ongoing actions?

### **3. Closing (30 minutes)**

- a. Have a celebration of our success & thanks for everybody's endeavor.
- b. Ask the participants to complete the post-test questionnaires and return them to the facilitator.

## Resources to support delivery

### A | The appreciative inquiry approach and the group design

#### 1 | Theoretical base

##### *Basic Assumption: Recovery-oriented services already exist within the in-patient context*

The appreciative inquiry (AI) approach, an affirmation process of organizational change that focuses on the positive and creative as a force for change, is used as a framework to organize this educational program for in-patient providers to transform their practice into recovery-orientation. AI approach has been used in business, government, healthcare, and education organizations all over the world. Developed by David Cooperrider in the mid-1980s, AI views an organization from positive perspectives instead of solving the problems. AI involves a process in which changes are facilitated through exploration and creation of positive possibility based on strengths. The focus on exploring positive possibilities can capture people's interest and is an effective way to engage people more deeply and for a longer time of learning.

The fundamental assumptions of the appreciative inquiry approach are compatible with the recovery concepts. The potential of AI as a tool for developing recovery education in in-patient settings is enormous. Both AI and recovery believe that:

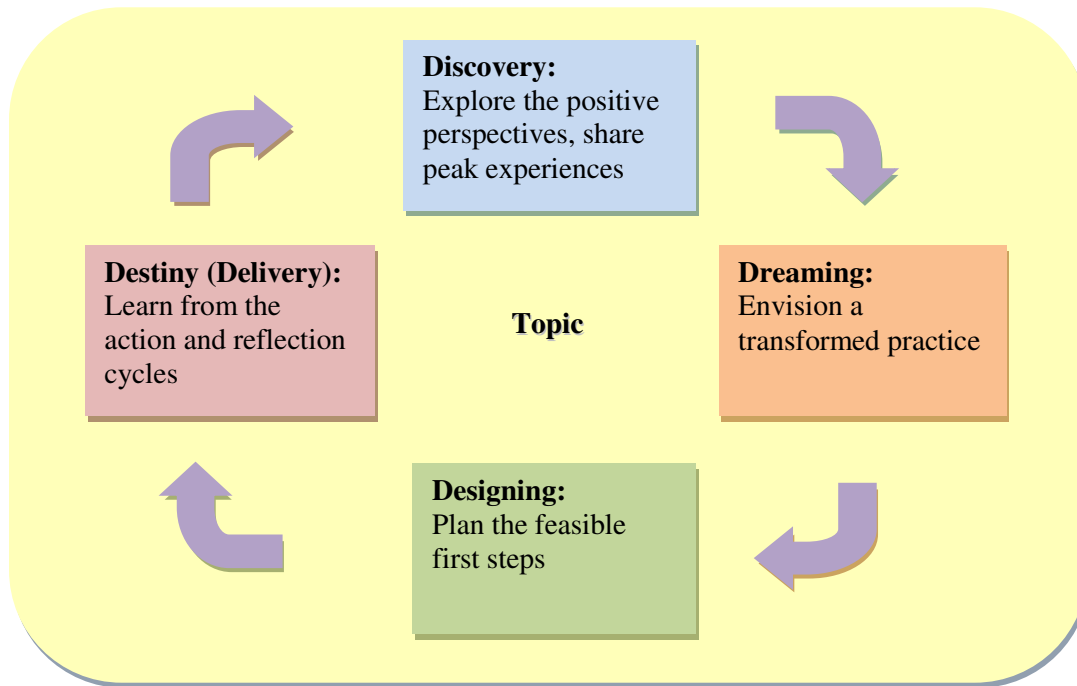
1. Through communication, people can shift their attention and action away from their problem analysis to lift up worthy ideals and productive possibilities for the future.
2. The emphasis is on appreciating people's strengths rather than concentrating on their problems.
3. The movement toward the use of appreciative and strength-based language rather than the use of deficit-based language such as dysfunction, sick, problem, defensive, disability, incompetent, burnout, etc. is promoted.

4. The change and transformation is not a linear process. AI and recovery are both processes that never end as the steps are repeated and people continue to learn in the process.
5. Like recovery which focuses on a person-centered intervention, when applied in the field of education, AI is a learner-centered approach wherein the instructor serves as a facilitator rather than content expert.
6. Recovery-oriented services encourage individuals' active engagement in their own recovery journey and emphasize the collaborative relationships between individuals and providers. Similarly, the application of AI in education is highly participatory in nature and supports people's active involvement in learning with a positive focus that promotes mutual trust and respect.

This educational program addresses providers' tensions based on the exploration of strengths embedded in the in-patient context. When applied, the distinctive features of the Appreciative Inquiry educational program are affirmative, inquiry-based, improvisational, and strength-based. These features can reduce providers' defensiveness to change, open chances of discussion, and create a positive framework that addresses their tensions.

## **2 | The changing process**

The researcher adapts the application of AI principles to better suit the in-patient providers' interdisciplinary education environment in order to enhance their learning experiences. The process begins with asking positive questions to identify what is positive and connect to the positive possibility in ways that heighten vision and actions for change. Through the 4-D cycle, providers can transform their current practice into more recovery-orientation by building on their strengths. The adaptive 4-D cycle is:



1. **Discovery:** Providers are encouraged to explore the positive possibilities of recovery-oriented practice in their current setting. The instructor facilitates providers to think creatively and drop the usual restrictions in the in-patient context. This phase reminds providers that they are capable of providing recovery-oriented services.
2. **Dreaming:** The providers work together to develop ideas of what the recovery-oriented practice might be. For example, they might think about future plans that won't cost much and will be welcomed immediately by everyone.
3. **Designing:** The providers work together to craft detailed plans based on what they have learned in the discovery and dream phases.
4. **Delivery:** The energy moves toward action planning and focuses on the providers' commitments for change. After the transformation, the team members review and validate the actions, reflect on what has

been learned throughout the process, celebrate accomplishments, and finally, apply the new learning in the next 4-D cycle or future practice.

### 3 | Key strategies to change

1. Collaborative and participative group dialogue: The use of group dialogue with an appreciative and positive focus on examining and exploring moments of excellence and then identifying opportunities for further improvement enables collective learning that evolves from experience and builds on the creative and positive energy generated by the information exchange. The questions are crafted with a positive focus designed to look for and strengthen the positive potential. Individual appreciation can become collective appreciation through group dialogue. The facilitator plays a key role in helping the small group maintain this positive focus. The diverse ages and backgrounds in the learning team provide a broad spectrum which stimulates creativity in peer feedback to further enhance collective learning.
2. Asking only positive questions: Asking questions is fundamental to learning and growth. Questions can challenge our assumptions, affirm our strengths and gifts, help us reflect on past successful experiences, foster creativity, and stimulate new thoughts. Asking only positive questions intends to build on people's past success, enable them to be positive, and then support them to act.
3. Self-reflection



## B | The management plan table & examples

Example:

Action Plans	The person in charge	Timeline	Indicators	Data collection methods
1. Brief a strength-based approach in the next team meeting	Ms. A	Next team meeting	a 5-minute brief	Team meeting minute
2. Discuss patients' strengths in the team meeting	Mr. B	Next team meeting	at least one strength is identified per patient	Team meeting minute
3. Document patients' strengths in their record	Ms. C	Next two weeks	at least one strength is documented per participants' patient	Participants' record
4. Incorporate a patient's strengths in his/her intervention plan	Mr. D	Next two weeks	At least one strength-based interview with a patient	Participants' record

Example:

Action Plans	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
1. Brief a strength-based approach in the next team meeting				Ms. A/ a brief				
2. Discuss patients' strengths in the team meeting				Mr. B suggests the team to do so....				
3. Document patients' strengths in their record		Mr. B – Ms. C ‡	Ms. A †		Mr. D ‡	Mr. D ‡		Mr. B †
4. Incorporate a patient's strengths in his/her intervention plan			Ms. A	Ms. C				Mr. B Mr. D

## References

Cooperrider, D. L., Whitney, D., & Stavros, J. M. (2008). *Appreciative Inquiry Handbook: For leaders of change*. San Francisco, CA: Crown Custom Publishing, Inc.

Davidson, L., Tondora, J., Lawless, M. S., O'Connell, M. J., & Rowe, M. (2009). *A practical guide to recovery-oriented practice: Tools for transforming mental health care*. New York, NY: Oxford University Press, Inc.

Preskill, H. S., & Catsambas, T. T. (2006). *Reframing evaluation through appreciative inquiry*. Thousand Oaks, CA: Sage Publications.

Reed, J. (2007). *Appreciative inquiry: Research for change*. Thousand Oaks, CA: Sage Publications.

## Module 1 Encouraging Participation



### Group 1

#### Case Scenario:

Mr. A, a 38-year-old man, was admitted two weeks ago to the in-patient ward having taken an overdose of sleeping tablets, while experiencing recurrent psychotic symptoms. Mr. A has a history of repeated psychotic episodes starting in his early 20s. Most of the time, his symptoms remained under control and he was able to function well in the community. He was unemployed. Before admission, Mr. A was isolated, staying much of the night to do crossword puzzles. He has not been in touch with his friends since his admission as he does not want them to know about his mental illness. Mr. A spends most of his time on the ward sleeping. Every morning when it's time to get up for breakfast, self-care, and making his bed, Mr. A does not want to do anything. He tells providers that he would like to stay in bed all day; he does not need to take a shower and get dressed. The ward staff have given him information about the activities available to him, but he states he is not interested. All he wants is to be left alone and allowed to go home.

*Staff dilemma: If Mr. A doesn't want to do anything or if he wants to stay in bed, that's his choice. However, as a provider, engaging him is my obligation since it can positively influence his health. I am not strict but there are some things that he has to do such as personal care. How can I engage Mr. A in activities to enable his recovery?*

## This learning module focuses on the dilemma of encouraging patients' participation in activities.

#### Introduction & Warm-up (20 minutes)

- Introduction of the group
- Warm-up activity: "Based on your recovery knowledge and reflections on Part One of the learning package, please describe one example of recovery-oriented practice in the unit"
- Discuss the case scenario: Mr. A

#### Questions & discussion (60 minutes)

##### Discovery Phase

- Describe an experience when you successfully engaged a patient in an activity.
- Reframe this case scenario into positives.

##### Dreaming Phase – developing a vision for the future of the program

- Image that you successfully engaged a patient to participate in activities.
- Image that it is one year from now. You are preparing for a presentation at a forum in this hospital that will share the successful story of the recovery-oriented program in your unit. You are quite proud to be the representative of your program. After the presentation, the audiences ask you the following questions. What are your answers?
  - \*What are the major changes inside your unit?
  - \* What factors have made this success possible and exemplary?
  - \* What is happening that makes you proud?

#### Closing (10 minutes)

- Reflection on today's discussion.
- Think about the action plans, collect related resources, and bring ideals to the next group.

## Module 1 Encouraging Participation



## Group 2

### Case Scenario:

Mr. A, a 38-year-old man, was admitted two weeks ago to the in-patient ward having taken an overdose of sleeping tablets, while experiencing recurrent psychotic symptoms. Mr. A has a history of repeated psychotic episodes starting in his early 20s. Most of the time, his symptoms remained under control and he was able to function well in the community. He was unemployed. Before admission, Mr. A was isolated, staying in much of the night to do crossword puzzles. He has not been in touch with his friends since his admission as he does not want them to know about his mental illness.

Mr. A spends most of his time on the ward sleeping. Every morning when it's time to get up for breakfast, self-care, and making his bed, Mr. A does not want to do anything. He tells providers that he would like to stay in bed all day; he does not need to take a shower and get dressed. The ward staff have given him information about the activities available to him, but he states he is not interested. All he wants is to be left alone and allowed to go home.

Use the data gathered through the discovery and dreaming phases to co-construct the action plans toward the vision

- Introduction & Warm-up (15 minutes)**
- Summarize the discussion at the last group session
  - Review case scenario Mr. A
  - Warm-up: video (How to engage participation)

- Questions & discussion (65 minutes)**
- Designing Phase*
- How might you engage with Mr. A in a way that would inspire hope?
  - If you could transform the ways in which you engage Mr. A, what would it look like and what would it take to happen?
  - Discuss possible support and resources:
    - At the individual level: What are Mr. A's personal support or resources?
    - At the program level: What are the support or resources which our program can provide with Mr. A?
    - At the system level: What are the support or resources which the mental health system can provide with Mr. A?

*Delivery Phase:* Let's think together about some first steps to engage in-patients.

- Think about yourself, your unit, and your hospital, what are some things that you can do tomorrow?
- What are some things that we can do in the next two weeks?
- Develop a management plan that helps keep the actions on time and on track.

- Closing (10 minutes)**
- Commit to making all the action plans happen in the next two weeks.
  - Set up a sharing board in this room.

## Module 1 Encouraging Participation



Group 3

Take a note of the results:

### Evaluation, Reflection, Sharing, and Celebration



**Introduction &  
Warm-up  
(20 minutes)**

- a. Summarize the action plans discussed at the second meeting
- b. Warm-up: Complete the sentence:  
“The best thing, in relation to recovery, that I did in the past two weeks was ...”
- c. Each person in charge of the action plans presents the results

**Questions &  
discussion  
(40 minutes)**

*Destiny & Reflection Phase*

- a. Reflection on the learning experience; Describe the actions you implemented in the past two weeks.
  - \*How did these actions work out?
  - \*What were the successes?
  - \*What needs to be further modified or improved?
  - \*What did you learn that will help or sustain the change?
- b. How can we share this learning experience with other staff?
- c. Can we take one idea in the group and implement this idea across the whole unit?
- d. Plan “what’s next”?
  - \* What do you like about the things you did?
  - \* What would you add to make the process stronger?
  - \* What will inspire ongoing actions?

**Closing  
(30 minutes)**

- a. Have a celebration of success & thanks for everybody’s endeavor
- b. Announce the time and place of the Learning Module 2

## Module 2 Strength-based Practice



### Group 1

#### Case Scenario:

Two providers received hospital funding to attend a national conference focusing on recovery-oriented mental health services. The topic of discussion at the conference was strength-based mental health services. The providers were responsible for bringing back their new learning about recovery and sharing strength-based concepts with their colleagues.

The providers want to connect the structure of the team with the strength-based practice to see if the team can implement some of the ideas. They decide to start at the multidisciplinary team meeting which is held regularly to plan care and treatment.

However, the regular team meeting would be: Nursing staff gave a rapid account of a patient's presentation over the last couple days. Other team members might express information about the patient's psychosocial, family, or behavioral problems. Then the psychiatrist would express his/her opinion on the medical treatment. Different disciplines appear to share a common language in the conceptualizing of problems. Finally, a treatment plan might be developed in order to solve the problems.

*Staff dilemma: Based on current structure of the team meeting, these two providers wondered how the strength-based approach can be applied by their team and what the best way is to introduce a different perspective which has not routinely been used.*

## Explore and dialogue on positive possibilities of the strength-based approach

#### Introduction & Warm-up (20 minutes)

- Introduction
- Warm-up activity: Think about this issue: "In the in-patient setting, negatives/problems of people served often seem more important than their strengths. The positive perspective is easier to be neglected".  
Now, let's practice thinking positively: Think about a current patient in the unit and discusses this patient's strengths.
- Discuss the case scenario and the strength-based approach

#### Questions & discussion (60 minutes)

- Discovery Phase
- Think of a time when you believe you operated from a strength-based approach with an in-patient
  - Think of a time when your in-patient team operated from a strength-based approach
- Dreaming Phase – developing a vision for the future of the program
- Imagine that you successfully enabled the use of a strength-based approach in their team. What does this use of a strength-based approach look like at the team meeting? What would the team members do that is different from what they are doing now? What resources would they need? What are the major changes in your team? What factors that have made this success possible?

#### Closing (10 minutes)

- Reflection on today's discussion.
- Think about the action plans, collect related resources, and bring ideals to the next group.

## Module 2 Strength-based Practice



**Group 2**

Our current team meeting procedure is ...	A strength-based team meeting procedure would be ...
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

*Staff dilemma: Based on current structure of the team meeting, these two providers wondered how the strength-based approach can be applied by their team and what the best way is to introduce a different perspective which has not routinely been used.*

Use the data gathered through the discovery and dreaming phases to co-construct the action plans toward the vision

- Introduction & Warm-up (15 minutes)**
- Summarize the last group session and introduce the objectives of today's group
  - Review the case scenario from last week
  - Warm-up: Using the above table to practice a "strength-based team meeting".

- Questions & discussion (65 minutes)**
- Designing Phase
- How might we enable the team members to accept and apply the strength-based perspective as a shared value?
  - What are possible enablers that can facilitate our team to adopt a strength-based approach?
  - If you could transform elements of your team meeting so that it operated from a strength-based approach, what would this look like?

Delivery Phase

- Let's think together about some first steps to introduce a strength-based perspective. What are some things that we can do tomorrow?
- What are some things that we can do in the next two weeks?
- Develop a management plan that helps keep the actions on time and on track.

- Closing (10 minutes)**
- Commit to making all the action plans happen in the next two weeks.
  - Set up a sharing board in this room.



Take a note of the results:

### Evaluation, Reflection, Sharing, and Celebration



- Introduction & Warm-up (20 minutes)**
- Summarize the action plans discussed at the second meeting
  - Warm-up: Complete the sentence: “To apply a strength-based approach, I successfully (did something....) in the past two weeks”
  - Each person in charge of the action plans presents the results
- Questions & discussion (40 minutes)**
- Destiny & Reflection Phase*
- Reflection on the learning experience: Describe the actions you did in the past two weeks to apply a strengths based approach.
    - \* How did these actions work out?
    - \* What were the successes?
    - \* What needs to be further modified or improved?
    - \* What did you learn that will help or sustain the change?
  - How can we share this learning experience with other staff on the unit?
  - How can we enable other staff, who did not participate in the training, to implement the strength-based approach on their team/unit?
  - Plan “what’s next”?
    - \* What do you like about things you did?
    - \* What would you add to make the process stronger?
    - \* What will inspire ongoing actions?
- Closing (30 minutes)**
- Have a celebration of success
  - Complete the post-test questionnaires and return them to the facilitator

*Thank you for your participation!*



## Chapter 5

### Phase Three: Program Evaluation

#### 5.1 Introduction

Recovery has become a widely promoted concept in the field of mental health. Providers represent an important environmental factor in people's recovery. The transformation of the mental health system toward one that is recovery-oriented has created a growing demand for training and education to equip providers with the attitudes, knowledge and behaviors underlying required recovery competencies. Education for providers has usually focused on exploring recovery concepts and the role of workers in facilitating people's recovery. Most of the recovery education involves workers with different disciplinary backgrounds, consumers, and family members joining together to share their understanding of recovery (Jacobson & Curtis, 2000).

Evidence is building for the positive impact of recovery education on service providers. Tsai and colleagues' research demonstrated that community-based providers who received more recovery training had more positive attitudes toward consumer recovery (Tsai, Salyers, & McGuire, 2011). Research has also indicated that training can promote adoption of recovery-oriented practices (Young, et al., 2005). As a result, there is an increased recognition of the important role of and imperative need for recovery education. However, while efforts to incorporate recovery education into practice continue, only a few empirically based recovery training programs have been reported.

This is Phase Three of a series of studies developing a recovery competency framework and related recovery education program for in-patient service providers. In the first phase of the study, a competency development approach was used to develop a recovery competency framework specifically tailored to the needs of in-patient providers. Eight corresponding core competencies with four to ten sub-

competencies were identified. Based on the competency framework, the second phase of the study was to develop a recovery education program for in-patient mental health providers in order to increase their recovery competencies. Finally, the third phase of the study tests the effectiveness of this recovery education program.

## **5.2 Background**

### **5.2.1 Recovery education**

A literature search was conducted to explore the evidence for recovery education in the MEDLINE, PsycINFO, EMBASE, Health and Psychosocial Instruments, and Google databases, using the following search terms: *mental health, recovery, recovery education, recovery training, training program, continued education, providers, and provider competencies*. Only studies related to recovery education were included in the review. The result showed that, although the transformation of mental health services to a recovery orientation requires the training of service providers in new recovery competencies, only six studies have investigated the influence of this training (see Table 5-1).

A mixed quantitative and qualitative pilot study evaluating a recovery training program was conducted in Scotland in 2006. This pilot involved 40 participants attending an initial 5-day recovery workshop with a 1-day follow-up three months later. Data collection included interviews with the training facilitators, participants, and managers; this process also involved pre- and post-training questionnaires, and diary records. The results indicated that the educational workshop positively changed participants' perceptions and knowledge of recovery, provided a networking opportunity, and improved confidence of recovery (Axiom Market Research and Consultancy, 2006).

Two articles discussed the effectiveness of a Collaborative Recovery Training (CRT) Program in Australia (Crowe, Deane, Oades, Gaputi, & Morland, 2006; Salgado, Deane, Crowe, & Oades, 2010). The Collaborative Recovery Training Program is a two-day program that focuses on providers' knowledge, attitudes, and hopefulness related to recovery. Crowe and colleagues, in 2006, used a self-report pre-post training, repeated-measures design with 248 community-based mental health workers to test the CRT program. The Recovery Attitudes Questionnaire (RAQ-7), the collaborative recovery knowledge scale, and the staff attitudes to recovery scale (STARS) were administered immediately before and after the program. The results indicated that provider attitudes, knowledge, and hopefulness toward consumer recovery improved with training (Crowe, Deane, Oades, Gaputi, & Morland, 2006). The second study of the CRT program was conducted by Salgado and colleagues in 2010. This was a single pre-post training measures design. One hundred and three providers attended the recovery training and completed RAQ-7, STARS, the Therapeutic Optimism Scale (TOS), Hope Scale, and the Recovery Knowledge Inventory (RKI) before and after the training. The results showed that provider attitudes and optimism toward recovery significantly improved over the course of training. Both articles demonstrate improvement of providers' recovery competencies following recovery training.

The final three articles are controlled trial studies. The first controlled trial was conducted at five large community mental health provider organizations to test the effectiveness of a consumer-led education program, Staff Supporting Skills for Self-Help. One hundred and fifty-one providers were recruited in the intervention group and 118 providers were in the control group. Outcomes were measured using the Competency Assessment Instrument (CAI) and semistructured interviews with managers and clinicians. The results showed significant improvement in providers' competencies for client-centered care (Young, et al., 2005).

Meehan and Glover (2009) assessed the effectiveness of a 3-day consumer-led recovery training program. The intervention group recruited providers from both in-patient and outpatient services. Two hundred and forty-seven of them attended the first training day, but the number decreased to 167 (67.6%) by the third day. Finally, one hundred and fourteen intervention group subjects and 64 comparison group subjects completed all pre, post, and 6-month follow-up assessments using the Recovery Knowledge Inventory (RKI). The results indicated that the training increased overall recovery knowledge for those who completed the training (Meehan & Glover, 2009).

In 2009, Peebles, et al. examined a recovery educational curriculum, Project GREAT, at the Medical College of Georgia, USA. This educational intervention was administered to 33 staff and residents of psychiatry and psychologists. Another 34 providers from a different institute served as a control group. The Project GREAT Recovery Knowledge Measure, RKI, Recovery Attitudinal Pre-Post Survey, and Attribution Questionnaire-27 (AQ-27) were used to evaluate participants' recovery knowledge and attitudes. Findings supported the effectiveness of the recovery educational curriculum in increasing providers' recovery competencies (Peebles, et al., 2009).

These six articles demonstrate the effectiveness of recovery training on provider competencies. Most of the research sites were in community settings. The educational programs tested included generic recovery training and consumer-led training programs. All of the research used self-developed instruments as well as some standardized recovery competency tests to evaluate the programs. A common limitation all research discussed is that the outcome measures did not link provider competencies to consumer outcomes.

**Table 5-1 Research of recovery education programs**

Program	Methods	Participants	Evaluation	Results
Working to Recovery training sessions, Scotland (Axiom Market Research and Consultancy, 2006)	A mix of quantitative and qualitative design	40	1. Interviews 2. Diary records 3. Self-developed evaluation questionnaires	The workshop changed perceptions and improved understanding of recovery.
Collaborative Recovery training program (CRTP), Australia	Self-report pre-post training repeated-measures design (Crowe, Deane, Oades, Gaputi, & Morland, 2006)	248 community-based mental health workers	1. RAQ-7 2. Collaborative Recovery Knowledge Scale (self-developed) 3. The Staff Attitudes to Recovery Scale (STARS) (self-developed)	Staff attitudes, hopefulness, knowledge improved after training.
	Simple pre-post training measures design (Salgado, Deane, Crowe, & Oades, 2010)	103	1. RAQ-7 2. STARS 3. TOS 4. Hope Scale 5. RKI	Training improved providers' recovery knowledge, attitudes, hopefulness, and optimism.
A consumer-led "Staff Supporting Skills for Self-Help", USA (Young, et al., 2005)	One-year controlled trial quasi-experimental design	Community providers Intervention group: 151 Control group: 118	1. CAI 2. Semistructured interviews with managers and clinicians	The intervention group showed improvement in competencies that are critical to client-centred care.
A consumer-led recovery training program, Australia (Meehan & Glover, 2009)	Non-equivalent control group study design	Intervention group: 114 Control group: 64	RKI	Providers demonstrated significant improvements in knowledge after training.
Project GREAT, The Medical College of Georgia, USA (Peebles, et al., 2009)	Non-equivalent control group, pre-post training repeated-measures design	Psychiatrists psychologists Intervention group: 33 Control group: 34	1. The Project GREAT Recovery Knowledge Measure (self-developed) 2. RKI 3. Recovery Attitudinal Pre-Post Survey 4. AQ-27	The training program increased providers' knowledge of recovery and a positive shift in recovery supporting attitudes.

\*RAQ-7: Recovery Attitude Questionnaire-7; TOS: The Therapeutic Optimism Scale; RKI: Recovery Knowledge Inventory; CAI: Competency Assessment Instrument; AQ-27: Attribution Questionnaire-27

## **5.2.2 Program evaluation**

### Kirkpatrick's model for assessing educational outcomes

Evaluation is used to determine the effectiveness of a program and ways in which the program can be improved. In this study, the evaluation was guided by Kirkpatrick's framework for educational evaluation (Kirkpatrick & Kirkpatrick, 2006), which includes four levels of outcomes. Level 1, evaluation of reaction, evaluates how participants felt about the learning experience. It is a measure of learner satisfaction. Level 2, evaluation of learning, measures the improvement in skills, increase in knowledge, and desired changes in attitudes before and after the education. One or more of these changes must take place if a change in behavior is to occur in the next level. Level 3, evaluation of behavior, evaluates the extent to which learning is applied back on the job. Five conditions are necessary for behaviors to be changed: The learner must have a desire to change, know what and how to change, work in a supportive climate, have encouragement and help, and be rewarded for changes. The first two requirements can be accomplished by the educational program, while the third and fourth conditions require organizational support. Finally, level 4, evaluation of results, assesses transfer to or impact on healthcare systems or society (Kirkpatrick & Kirkpatrick, 2006).

In this study, the assessment of the recovery education program was based on level 1 to 3 of the Kirkpatrick's framework. The three research sites in this study are identified as hospitals with recovery-oriented visions. The supportive climate is consistent with the requirements of level 3. Level 4 outcomes were beyond the scope of the current education program.

## **5.2.3 Purpose statement and research questions**

The purpose of the third phase is to test the effectiveness of the recovery education program for in-patient hospital-based mental health providers to increase their recovery competencies. *In-patient*

*providers* are defined as mental health professionals who currently provide clinical services in in-patient units and include managers, nurses, occupational therapists, psychiatrists, psychologists, recreation therapists, and social workers. *Recovery competency* is defined as attitudes, knowledge, skills, and behaviors required in providing recovery-oriented services. Phase Three seeks to answer the following research questions: Can a focused, context specific educational program improve the recovery competencies of in-patient mental health providers? The study hypothesis is that the implementation of the educational program will improve mental health providers' recovery competencies. This hypothesis is based on the assumption that exposure to recovery concepts and engaging in recovery-related discussion will increase providers' recovery knowledge, attitudes, skills, and behaviors. The specific research question thus becomes the following: After completing the recovery education program, will in-patient providers show significant improvement in recovery knowledge, attitudes, and sense of competency?

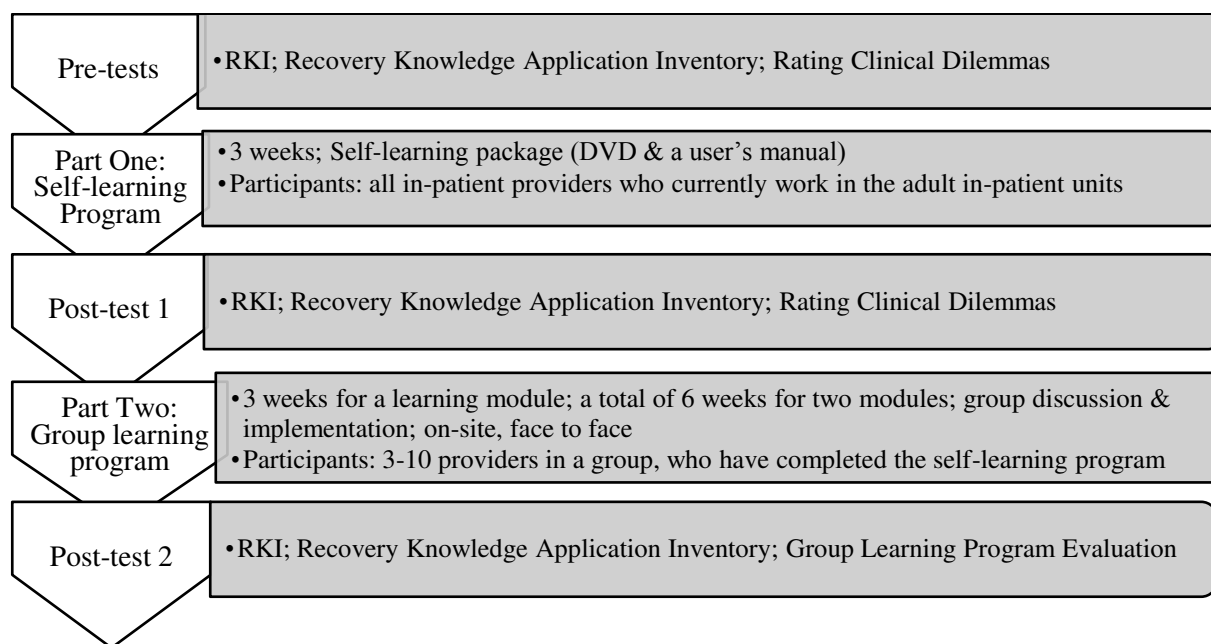
## **5.3 Methods**

### **5.3.1 Research design**

A pilot study with a simple pre-test/post-test design was used. Three tertiary care hospitals providing mental health services in Ontario were recruited as research sites. All in-patient providers working in adult in-patient units in these sites were invited to participate in the study. At baseline (prior to receiving the educational program) all participants completed the Recovery Knowledge Inventory (RKI) (Bedregal, O'Connell, & Davidson, 2006), and two investigator-developed questionnaires, the Recovery Knowledge Application Inventory and Rating Clinical Dilemmas, rating their sense of their own competencies and perceived recovery-related dilemmas. Then, they participated in Part One of the education program, the self-learning program. After participants completed the self-learning program, the post-tests were administered again using the same instruments.

Part two of the education program is the group learning program. Participants who had completed the first part, the self-learning program, were invited to participate in the group learning sessions lead by identified recovery specialists, trained in the implementation of the program, at their respective sites. After all group sessions, a Group Learning Program Evaluation developed by the investigator was used to understand participants' experience in the group learning process. The Recovery Knowledge Inventory and the Recovery Knowledge Application Inventory used in Part One were administered again to see if there was any change in participants' recovery competencies (see Figure 5-1). It is expected that Phase Three will provide important feedback that will facilitate revisions and will eventually lead to further testing using a randomized controlled trial research design.





**Figure 5-1 The research design**

### 5.3.2 Participants

Prior to beginning Phase One of the research, the investigator contacted three tertiary care hospitals that provide mental health services in Ontario to recruit their participation in this study. At that time, two hospitals had expressed interest in the study and participated in Phase One of the research. These sites expressed interest in participating in Phase Three. In addition, the investigator presented the findings from Phase One (the recovery competency framework) at the Annual Conference of Psychosocial Rehabilitation Canada in September 2010. There was much interest in participating in Phase Three from the audience by representatives from 3 additional sites. The investigator contacted these potential hospital sites to set up the research procedures. Finally, a total of three hospitals were recruited as the research sites. They were: 1) Centre for Addiction and Mental Health (CAMH), Toronto; 2) Lakehead Psychiatric

Hospital of the St. Joseph's Health Care, Thunder Bay; and 3) Regional Mental Health Care London and St. Thomas. Ethics approvals from each site are shown in Appendix C, D, and E.

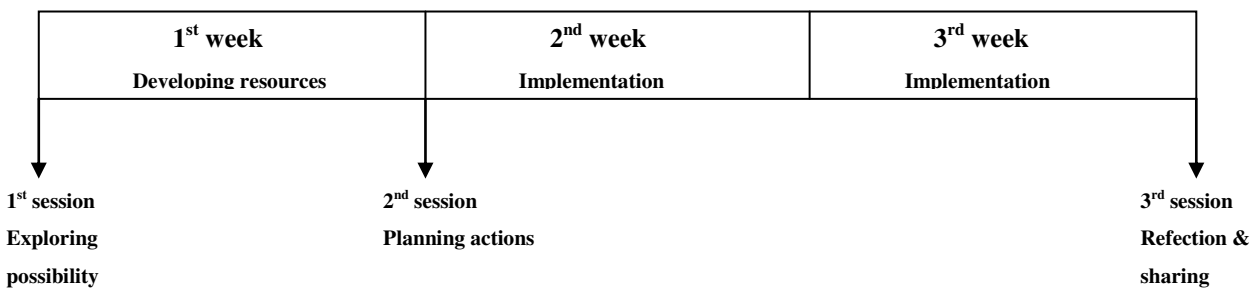
Multi-disciplinary in-patient providers who currently provide care to individuals with serious mental illness between the ages of 18-65 on selected in-patient units were invited to participate in this study. Clinical staff to be recruited included managers, nurses, occupational therapists, psychiatrists, psychologists, recreation therapists, and social workers. Where peer-providers were part of the in-patient staff, they were not recruited because peer providers may not perceive as many tensions as professionals in in-patient recovery-oriented practice. All providers, including full-time, part-time, and casual staff were invited to participate in this study. For Part Two, the group learning program, participants who had completed Part One, the self-learning program, were invited to participate in the group learning program. There could be 3 to 10 participants in a group and 1 or 2 groups in a given site.

### **5.3.3 Intervention: The recovery education program**

Part One, the self-learning program introduces basic recovery concepts, the in-patient context, and the recovery competency framework. The package includes a DVD and a guiding booklet navigating the participants through the learning process. Participants used personal computers at home or at the work place to access the program. The program was designed to take 4-5 hours to complete, however it is a self-paced learning experience, accessible at any time. For the purposes of this study, participants were given three weeks to complete the program. Part Two, the group learning program, consists of two learning modules which focus on two real-life dilemmas relevant to in-patient settings and applies the Appreciative Inquiry (AI) approach to address these dilemmas. Learning is enhanced if participants from different disciplines join together to provide interdisciplinary perspectives. The group program is delivered by a local facilitator at each site. The investigator provided training and a resource toolkit to the

facilitators. It is important to have group facilitators who have an expertise in recovery, and have the role of supporting and training recovery in the sites.

The approximate time to complete a learning module is 3 weeks. There are 3 group learning sessions required in a learning module. One group learning session per week is recommended (See Figure 5-2 for the recommended time schedule). Each session takes 90 minutes to complete. It takes 6 weeks in total to complete the two group learning modules.



**Figure 5-2 Group learning schedule for each learning module**

### 5.3.4 Assessment Instruments

There are four instruments used in this study: 1) The Recovery Knowledge Inventory (RKI) (Bedregal, O'Connell, & Davidson, 2006); 2) The Recovery Knowledge Application Inventory - an investigator-developed instrument measuring in-patient providers' sense of competencies regarding the application of recovery knowledge; 3) Rating Clinical Dilemmas - an investigator-developed instrument measuring providers' perceived dilemmas in practice; and 4) The Group Learning Program Evaluation -

an investigator-developed learning group evaluation to understand participants' group learning experiences (see Appendix I).

The Recovery Knowledge Inventory measures providers' knowledge and attitudes towards four recovery components: 1) roles and responsibilities in recovery; 2) non-linearity of the recovery process; 3) the role of self-definition and peers in recovery; and 4) expectations regarding recovery. There are 20 items on the RKI which follow a Likert-style response format ranging from 1 (strongly disagree) to 5 (strongly agree). The Cronbach's alphas of reliability analysis for four components were 0.81, 0.70, 0.63, and 0.47, respectively. Theoretically derived domains and item-component loadings are also reported. The Recovery Knowledge Inventory has been used as a tool to investigate mental health providers' recovery knowledge and to evaluate the effectiveness of recovery-focused training (Cleary & Dowling, 2009; Meehan & Glover, 2009; Peebles, et al., 2009; Salgado, Deane, Crowe, & Oades, 2010).

The second and third parts of the assessment is the Recovery Knowledge Application Inventory and Rating Clinical Dilemmas - two investigator-developed instruments measuring providers' sense of competencies to apply the recovery knowledge and their perceived dilemmas in practice in terms of frequency and perception of being able to negotiate these dilemmas. The design of the instruments is based on the recovery competency framework developed in Phase One of this research, which addresses clinical tensions and identifies related competencies to reduce the tensions. There are 12 items measuring individuals' sense of competencies in the Recovery Knowledge Application Inventory and 10 items measuring perceived dilemmas in the Rating Clinical Dilemmas. All items consist of a brief statement with a five-point Likert response format from 1 (strongly disagree/never/not at all) to 5 (strongly agree/always/to a great extent). Three spaces are left at the end of the questionnaire for participants to contribute other dilemmas they have faced. It takes about 10-15 minutes to finish the RKI, the Recovery Knowledge Application Inventory, and Rating Clinical Dilemmas.

The fourth assessment is an investigator-developed Group Learning Program Evaluation to understand the effectiveness of the group learning modules in meeting providers' needs. The design of the questionnaire is based on Kirkpatrick's four levels of training evaluation (Kirkpatrick & Kirkpatrick, 2010). There are 18 items describing the learning experiences with a five-point Likert response format from 1 (strongly disagree) to 5 (strongly agree) and 3 open-ended questions inviting participants' comments for further improvement of the educational program. It takes about 10 minutes to complete the learning group evaluation.

### **5.3.5 Data collection procedure**

A liaison was identified at each site to facilitate the study.

Part One, the self-learning program: First, the investigator contacted the in-patient program managers to seek support for participation. Then the liaison distributed the information sheet and explained the study at an in-patient ward meeting (see Appendix H). The unit leader passed the information on to those who did not attend the meeting because of working shifts. The liaison then set a sealed box in the nursing station. Staff who were interested in participating in the study returned the attached slip to the box. Second, the liaison set up a meeting to explain the study for providers who were interested in participating. In this meeting, the educational materials, the consent form, and the pre-tests were distributed. Staff who agreed to participate signed the consent form, completed the pre-tests, and returned them to the liaison. Third, the participants completed the educational materials of Part One at their own pace over three weeks. They could contact the investigator whenever they had any questions regarding the education program. Finally, after three weeks, the liaison distributed the post-tests to the participants and asked them to finish and return these within one week.

Part Two, the group learning program: First, the investigator identified a group facilitator at each site and provided training to the facilitators. Second, the facilitator actively invited potential participants to the group learning program. Third, the facilitators set up the time for group learning sessions with the participants who agreed to join the learning group, prepared the place for the group sessions, and sent the final detailed information to the participants, including time and place for the meetings. Finally, the group sessions were held once a week for 6 weeks. At the end of the last group session, the participants were asked to finish the post-tests and the Group Learning Program Evaluation.

The data collected included: 1) the demographic data; 2) pre-test and post-test scores of the RKI, the Recovery Knowledge Application Inventory, and Rating Clinical Dilemmas; and 3) the Group Learning Program Evaluation. The demographic data included participants' age, gender, job title, profession, educational level, previous recovery-training experiences, and years of experience in in-patient programs and the mental health field.

### **5.3.6 Data analysis**

There were three measurement periods in this study: 1) pre-test at baseline, 2) post-test 1 after the self-learning program, and 3) post-test 2 after the group learning program. The SPSS version 18.0 for Windows was used to manage and analyze the data. Descriptive statistics and the comparisons of the demographic data for three sites were conducted. There were several considerations regarding the use of proper statistical methods to compare the measurements before and after the education intervention. Since the final sample size was small, nonparametric methods of comparison were considered most appropriate. Therefore, the following nonparametric tests were performed: 1) Wilcoxon match paired tests to compare the individual pre-test and post-test 1 scores of the RKI, the Recovery Knowledge Application Inventory, and Rating Clinical Dilemmas; 2) Wilcoxon match paired tests to compare the post-test 1 and post-test 2

scores of the RKI and the Recovery Knowledge Application Inventory; and 3) Freidman's tests to compare the differences of the RKI and the Recovery Knowledge Application Inventory across three assessments. The Likert scale values yield ordinal data; they can be transformed to continuous data by computing the mean of all questions. Parametric tests can be applied in this case if the data meet the assumption that the sampled population possesses a normal probability distribution. In this study, t-tests and repeated measures analysis of variance (ANOVA) were conducted as a means to verify the results of the non-parametric tests. Finally, a descriptive analysis of the Group Learning Program Evaluation was performed.

## **5.4 Results**

Of the 26 in-patient providers from three research sites, twenty-two (84.6%) were female. Thirteen (50%) participants were nurses; other professions included administrators, occupational therapists, social workers, psychologists, and recreational therapists. Except for the notable lack of participation by psychiatrists, the sample reflected a range of in-patient service providers. The demographic characteristics of the study participants for each site are outlined in Table 5-2. Significant differences were found between sites on years of experience in the mental health field and previous recovery training. Site 3 had significantly more years of experience than the other 2 sites. Also, compared to site 1 (38.46%) and site 2 (50%), site 3 had a higher proportion of participants (85.71%) who had not received any recovery-related training before this study.

**Table 5-2 The participant profile**

	Total (N=26)	Site 1 (n=13)	Site 2 (n=6)	Site 3 (n=7)	Tests of site difference
Sex					
Female	22 (84.6%)	12	4	6	
Male	4 (15.4%)	1	2	1	
Age					
25-29	3 (11.5%)	1	1	1	
30-39	7 (26.9%)	5	1	1	
40-49	7 (26.9%)	2	4	1	
50-59	9 (34.6%)	5	-	4	
Job					
Administrator	2 (7.7%)	2	-	-	
Nurse	13 (50%)	6	1	6	
OT	4 (15.4%)	2	1	1	
Social worker	2 (7.7%)	1	1	-	
Psychologist	1 (3.8%)	-	1	-	
Other	4 (15.4%)	2	2	-	
Education					
College	7 (26.9%)	2	2	3	
Bachelor	8 (30.8%)	6	1	1	
Master	8 (30.8%)	5	2	1	
PhD	1 (3.8%)	-	1	-	
Other	2 (7.7%)	-	-	2	
Years of experience (SD)					
Mental health field	11.81(9.05)	9.04 (7.43)	8.75 (5.69)	19.57 (10.37)	3>1,2 <sup>a</sup>
Current in-patient unit	5.02 (3.44)	4.35 (3.34)	4.83 (4.13)	6.43 (3.05)	
Previous recovery training					
Yes	12 (46.2%)	8 (61.54%)	3 (50%)	1 (14.29%)	
No	14 (53.8%)	5 (38.46%)	3 (50%)	6 (85.71%)	

<sup>a</sup> one way ANOVA, post-hoc tests,  $p < .05$

#### 5.4.1 The self-learning program evaluation

Table 5-3 summarizes the results for the self-learning program. Twenty-three complete and valid pre-test and post-test measures were available for the self-learning program (site 1: n=10; site 2: n=6; site 3: n=7). The Wilcoxon Signed Ranks Test showed that the self-learning program elicited a statistically significant change in the Recovery Knowledge Inventory (RKI) among all participants (n=23,  $Z = -2.55$ ,  $p = .011$ ). To analyze the results by sites, participants from site 3 showed a significant change in the RKI



( $n=7$ ,  $Z = -2.37$ ,  $p= 0.018$ ). For site 1 and 2, the RKI mean scores did increase after the intervention, but they were not statistically significant.

For the Recovery Knowledge Application Inventory, there was a significant improvement across all participants following the self-learning program ( $n=23$ ,  $Z = -3.48$ ,  $p= 0.001$ ). To analyze the data by sites, participants from site 1 ( $n=10$ ,  $Z = -2.56$ ,  $p = 0.011$ ) and site 3 ( $n=7$ ,  $Z = -2.04$ ,  $p = 0.041$ ) demonstrated significant changes. Although site 2 did not show statistically significant change, the mean scores did increase in post-test.

Before and after the self-learning program, participants were asked to rate perceived dilemmas in their daily practice in terms of frequency and perception of being able to negotiate these dilemmas. However, the results of Rating Clinical Dilemmas indicated that there was no significant difference between pre and post-rating of each dilemma on frequency and perceived competency (see Appendix J). These results suggested that the self-learning program had an effect on increasing participants' general sense of recovery competencies, but not on perceived dilemmas and related specific competencies.

**Table 5-3 Pre- and post-training comparison for the self-learning program on the Recovery Knowledge Inventory and the Recovery Knowledge Application Inventory**

		Mean	Median	Wilcoxon Signed Ranks Test	
				Z	p (2 tailed)
<b><i>Recovery Knowledge Inventory</i></b>					
All (n=23)	Pre-test	3.87	3.90		
	Post-test 1	4.05	4.15	-2.55	<b>.011*</b>
Site 1 (n=10)	Pre-test	3.91	3.98		
	Post-test 1	3.95	4.05	-5.2	.600
Site 2 (n=6)	Pre-test	3.94	4.00		
	Post-test 1	4.09	4.10	-1.08	.279
Site 3 (n=7)	Pre-test	3.74	3.85		
	Post-test 1	4.14	4.25	-2.37	<b>.018*</b>
<b><i>Recovery Knowledge Application Inventory</i></b>					
All (n=23)	Pre-test	4.13	4.00	-3.48	<b>.001*</b>
	Post-test 1	4.33	4.25		
Site 1 (n=10)	Pre-test	4.11	4.04	-2.56	<b>.011*</b>
	Post-test 1	4.32	4.30		
Site 2 (n=6)	Pre-test	4.28	4.13	-1.63	.102
	Post-test 1	4.39	4.33		
Site 3 (n=7)	Pre-test	4.02	3.85	-2.04	<b>.041*</b>
	Post-test 1	4.30	4.25		

\* p<.05

#### **5.4.2 The group learning program evaluation**

Recruiting participants for the group learning program was challenging. All liaisons from three sites indicated that it was difficult to arrange the group meeting time for in-patient providers due to staff shortages, staff working in different shifts and related difficulties in arranging schedules, and difficulties with arranging coverage to allow for attendance at group learning sessions. The final number of group participants in site 1 was 7. However, 6 of these participants completed only one group learning module (either module 1 or 2); and only 1 participant completed both modules. In site 2, all 6 participants in the

self-learning program participated in both group learning modules. Site 3 was the most difficult site with respect to recruitment. The liaison tried for two months and finally failed to coordinate the group meetings. Thus, the total number of participants for the group learning program was 13, 7 from site 1 and 6 from site 2. In addition to the analysis by sites, data were analyzed by the number of group modules that participants attended. Therefore, for the purposes of this analysis, one group is called the “complete group” and consisted of 7 participants who completed two group modules (1 from site 1 and 6 from site 2); the second group is called the “incomplete group” with 6 participants from site 1 who just attended one group module. Wilcoxon Signed Ranks Tests were conducted to determine whether there were any significant differences in RKI and the Recovery Knowledge Application Inventory before and after the group intervention between different sites and between different numbers of group modules attended.

The evaluation results are shown in Table 5-4. The complete group reached significant difference in the RKI before and after the group intervention ( $n=7$ ,  $Z=-1.95$ ,  $p=.051$ ). In terms of the Recovery Knowledge Application Inventory, only site 2 showed significant improvement ( $n=6$ ,  $Z = -2.20$ ,  $p = 0.028$ ) with a median score of 4.33 (4.00-4.79) before the group intervention and 4.88 (4.58-5.00) after the group intervention.

**Table 5-4 Pre- and post-training comparison for the group learning program on the Recovery Knowledge Inventory and the Recovery Knowledge Application Inventory**

	Post-test 1 (before group)		Post-test 2 (after group)		Wilcoxon Signed Ranks Test	
	mean	median	mean	median	Z	p (2 tailed)
<b><i>Recovery Knowledge Inventory</i></b>						
All (n=13)	4.05	4.10	4.14	4.20	-1.40	.162
<i>by sites</i>						
Site 1 (n=7)	4.02	4.10	4.02	4.20	-3.41	.733
Site 2 (n=6)	4.09	4.10	4.30	4.23	-1.68	.093
<i>By the number of group module participation</i>						
Incomplete (n=6)	4.02	4.23	3.99	4.18	-1.05	.293
Complete (n=7)	4.08	4.05	4.29	4.20	-1.95	<b>.051</b>
<b><i>Recovery Knowledge Application Inventory</i></b>						
All (n=13)	4.41	4.33	4.62	4.67	-1.76	.079
<i>by sites</i>						
Site 1 (n=7)	4.43	4.33	4.45	4.42	-0.09	.932
Site 2 (n=6)	4.39	4.33	4.82	4.88	-2.20	<b>.028*</b>
<i>by the number of group module participation</i>						
Incomplete (n=6)	4.44	4.38	4.51	4.54	-0.43	.671
Complete (n=7)	4.38	4.33	4.71	4.75	-1.78	.075

\* p<.05

Participants were asked to rate 18 statements about the group learning experience on a 5-point Likert scale, from 1 “strongly disagree” to 5 “strongly agree”. In the Group Learning Program Evaluation, items 1 to 8 and 18 are categorized as Kirkpatrick’s level 1 of learning evaluation, which is a measure of learner satisfaction and how participants felt about the learning experience. All participants showed high satisfaction at this level: 4.31 for all participants, 4.03 for site 1, and 4.63 for site 2 (out of 5).

Kirkpatrick’s level 2 of learning evaluation is related to knowledge and skill acquisition. Level 2 was measured using the RKI, which was reported in the previous section. Items 9 to 17 are categorized as Kirkpatrick’s level 3 of learning evaluation, which focuses on changes of behaviors in practice. However,

objectively assessing behavioral changes related to participation in the learning experience was beyond the scope of this study. Instead, the researcher evaluated participants' self-report of their implementation of learning back on the job. The result showed that the perception of implementation was high for participants from site 2 (n=6, mean=4.52 out of 5), but only moderate for participants from site 1 (n=7, mean=3.78 out of 5). The total mean scores for the full question set were 4.21 for all participants, 3.9 for site 1, and 4.57 for site 2 (out of 5). Table 5-5 provides the means by each item, level 1, level 3, and total average.

Using Mann-Whitney tests to compare two sites, site 2 had significantly higher satisfaction for level 1 score ( $z = -2.52, p = .012$ ) and for the total mean score ( $z=-2.295, p=.022$ ). At level 3, site 2 had a higher score than site 1, with p values at .059 approaching, but not reaching significance.

Both sites 1 and 2 had positive group experiences, but site 2 showed greater satisfaction. Moreover, the sense of general competency improved for site 2 participants after the group intervention. The results suggested that the learning group in site 2 might have higher group cohesiveness because each member had full group participation, whereas the majority of site 1 participants (6 out of 7) had incomplete participation.

**Table 5-5 The results of Group Learning Program Evaluation**

Items	Kirkpatrick's level	All (N=13)	Site 1 (n=7)	Site 2 (n=6)	
1. I enjoyed this group learning experience.	1	4.69	4.43	5.00	
2. This program was worthwhile in terms of my time away from normal job duties.	1	4.38	4.14	4.67	
3. The topics and exercises covered in the learning program were relevant to my job.	1	4.38	4.00	4.83	
4. The handouts would be of help to me.	1	3.77	3.43	4.17	
5. The group schedule was suitable.	1	4.15	4.00	4.33	
6. The facilities and materials were suitable.	1	4.23	4.14	4.33	
7. The group learning method was suitable.	1	4.62	4.29	5.00	
8. I will recommend this program to my colleagues.	1	4.31	4.00	4.67	
9. There were noticeable and measurable changes in the way I practice during the past six weeks.	3	3.46	3.14	3.83	
10. I feel like the learning experience will help me do my job better.	3	4.00	3.57	4.50	
11. The learning experience was helpfulness to self development.	3	4.15	3.57	4.83	
12. I will be able to apply much of the learning experience to my job.	3	4.15	4.00	4.33	
13. The group learning experience enables helpful change to the way I think and behave afterward.	3	3.85	3.29	4.50	
14. I feel that I am able to transfer the learning to another clinical situation.	3	4.15	4.00	4.33	
15. I feel that I am well equipped to provide recovery-oriented services in my unit.	3	4.62	4.43	4.83	
16. I am eager to provide recovery-oriented services in my unit after leaving the educational program.	3	4.46	4.14	4.83	
17. Any change resulting from the group experience will promote recovery-oriented practices for me and my team.	3	4.23	3.86	4.67	
18. Overall, I am satisfied with this educational program.	1	4.25	3.83	4.67	
<b>Mean – level 1 (items 1-8 and 18)</b>		<b>4.31</b>	<b>4.03</b>	<b>4.63</b>	2>1*
<b>Mean – level 3 (items 9-17)</b>		<b>4.12</b>	<b>3.78</b>	<b>4.52</b>	
<b>Mean - Total (18 items)</b>		<b>4.21</b>	<b>3.90</b>	<b>4.57</b>	2>1*

\* Mann-Whitney tests , p<.05

Content analysis of the comments and suggestions in response to the 3 opened-ended questions revealed participants' support of the education program (see Table 5-6). All participants spoke positively about the group learning experience. The majority of the participants stated that the group learning

program assisted them in developing practice skills when facing recovery-related dilemmas. They highlighted the benefits of solving real-life dilemmas, having action plans and actual implementation, having chances to share ideas with other team members, and knowing the resources. The group content and format was generally appreciated. When asked about barriers for implementing group action plans, the participants drew attention to system level barriers such as time, support, and resource constraints as well as personal level barriers like “not being assertive”. Barriers at the system level are an important consideration for promotion of recovery in the in-patient setting. The final question asked for participants’ suggestions for making the program more helpful. The first suggestion was the broad dissemination of the education program. The participants hoped that more staff could be involved in and benefit from the education program. Thus all team members can get more consensus on recovery. The second suggestion was to provide more practical cases. Having support and follow-up for changes were the final two suggestions. The results indicated that “being practical” is the most important component for the design of the in-patient education. The content must relate to real situations and be applicable to daily practice. There was general agreement among the participants that the recovery education program in this study could meet such needs.

**Table 5-6 Analysis of open-ended questions**

Main themes	Sample quotes
<b><i>The most helpful things in the group learning program:</i></b>	
1. Content: discuss real-life dilemmas	solve problem in real situation /chance to reflect on existing barriers and potential changes /case study
2. Homework: actual implementation	allow me to practice /making actual change /action immediately /collaboration with others
3. Group discussion: sharing ideas and knowing resources	input from others /discuss my problem /chance to interact with others /group dynamic & sharing idea /multidiscipline discussion /variety of suggestions /ask for help in difficult situation /knowing where to go for help and information
<b><i>Barriers for the implementation of group action plans:</i></b>	
1. time	time management is a 'big deal' /time limitation
2. being assertive	being assertive is somewhat difficult
3. lack of support	feeling it would not be accepted by others /management
4. resources constraints	money constraints /staffing constraints
<b><i>Further suggestions for the program:</i></b>	
1. Involving more staff	all staff should get a chance to attend/ provide for all staff/ offer it to all nursing staff and front line healthcare workers
2. Providing more practical cases	more actual solutions and options /I liked the information that was applied to inpatient programs. It is always helpful to hear about other inpatient programs – more examples would be great!
3. Having support for changes	have real time and support for actual change to be tried & discussed
4. Having follow-up for implementation	it's nice to have reminders to implement the strategies –having like a post follow-up session 1x year

### 5.4.3 Results across the three measurement periods

In site 1, because pre-test data for 3 participants were not collected, there were only 4 participants who provided valid data across the three measurement periods. The results of the Freidman's tests showed that across the three measurement periods the education program elicited a significant change in the RKI for all participants ( $n=10, \chi^2 = 5.898, df=2, p = .052$ ) and in the Recovery Knowledge Application



Inventory for all participants ( $n=10$ ,  $\chi^2 = 7.514$ ,  $df=2$ ,  $p = .023$ ). When considered by sites, significant change was observed on site 2 (RKI:  $n=6$ ,  $\chi^2 = 7.913$ ,  $df=2$ ,  $p = .019$ ; Recovery Knowledge Application Inventory:  $n=6$ ,  $\chi^2 = 11.143$ ,  $df=2$ ,  $p = .004$ ) but not site 1 (see Table 5-7).

**Table 5-7 The repeated measures comparisons across three assessments on the Recovery Knowledge Inventory and the Recovery Knowledge Application Inventory**

		Mean	Median	Freidman's test			P (2 tailed)
				Mean rank	$\chi^2$	df	
<b><i>Recovery Knowledge Inventory</i></b>							
All (n=10)	Pre-test	4.07	4.00	1.40	5.895	2	<b>.052</b>
	Post-test 1	4.22	4.18	2.20			
	Post-test 2	4.34	4.30	2.40			
Site 1 (n=4)	Pre-test	4.27	4.29	1.63	2.533	2	.282
	Post-test 1	4.42	4.46	2.63			
	Post-test 2	4.39	4.41	1.75			
Site 2 (n=6)	Pre-test	3.94	4.00	1.25	7.913	2	<b>.019*</b> post hoc: ns for all pairs with Bonferroni correction
	Post-test 1	4.09	4.10	1.92			
	Post-test 2	4.30	4.23	2.83			
<b><i>Recovery Knowledge Application Inventory</i></b>							
All (n=10)	Pre-test	4.23	4.13	1.35	7.514	2	<b>.023*</b> post hoc: pre-test/post- test 2, p=.014
	Post-test 1	4.40	4.33	2.15			
	Post-test 2	4.58	4.58	2.50			
Site 1 (n=4)	Pre-test	4.17	4.13	1.50	3.500	2	.174
	Post-test 1	4.42	4.33	2.75			
	Post-test 2	4.23	4.21	1.75			
Site 2 (n=6)	Pre-test	4.28	4.13	1.25	11.143	2	<b>.004*</b> post hoc: ns for all pairs with Bonferroni correction
	Post-test 1	4.39	4.33	1.75			
	Post-test 2	4.82	4.88	3.00			

\*  $p < .05$

Since using Wilcoxon tests to compare differences for each pairs with Bonferroni correction in post-hoc tests were not sensitive enough to detect changes of each pair, repeated measures ANOVA with post-hoc tests were also conducted to assist with the interpretation of the data. The results of ANOVA were similar to Freidman’s tests, but more sensitive in the post-hoc tests. Results presented in Table 5-8, demonstrate that site 2 showed more improvement in the RKI and the Recovery Knowledge Application Inventory across three measurements than site 1, especially for the group effects on improving sense of recovery knowledge application.

**Table 5-8 Repeated measures ANOVA, Within-subjects analysis for the RKI and the Recovery Knowledge Application Inventory**

	Pre-test mean (SD)	Post-test 1 mean (SD)	Post-test 2 mean (SD)	Within-subjects analysis		
				F	p	
<b><i>Recovery Knowledge Inventory</i></b>						
All (n=10)	4.07 (.38)	4.22 (.28)	4.34 (.21)	5.501	<b>.014*</b>	post hoc: pre-test/post-test 2*
Site 1 (n=4)	4.27 (.41)	4.41 (.32)	4.39 (.17)	1.039	.41	
Site 2 (n=6)	3.94 (.32)	4.09 (.16)	4.30 (.23)	5.605	<b>.023*</b>	post hoc 2: pre-test/post-test 2*
<b><i>Recovery Knowledge Application Inventory</i></b>						
All (n=10)	4.23 (.33)	4.40 (.31)	4.58 (.35)	4.994	<b>.019*</b>	post hoc: pre-test/post-test 1*; pre-test/post-test 2*
Site 1 (n=4)	4.16 (.18)	4.41 (.23)	4.23 (.14)	3.280	.109	
Site 2 (n=6)	4.28 (.42)	4.39 (.38)	4.82 (.21)	10.316	<b>.004*</b>	post hoc: post-test 1/post-test 2; pre-test/post-test 2*

\* p<.05

Table 5-9 summarizes the results by different sites. Because there were missing data in site 1, the number of participants at each point of comparison was not the same. It is only meaningful to see the results separately. Therefore, in site 1, the self-learning program elicited positive effects on the

participants' sense of recovery knowledge application. In site 2, although there were no significant changes on the RKI in Part One or Part Two alone, improvement was shown across the whole learning program. For the sense of recovery knowledge application, the main significant effect was found in the group learning part. In site 3, the significant effects were found both on the RKI and the sense of recovery knowledge application in the self-learning part.

**Table 5-9 Summary of results by study sites**

	The Recovery Knowledge Inventory			The Recovery Knowledge Application Inventory		
	Part One: Self-learning	Part Two: Group learning	Part One + Two	Part One: Self-learning	Part Two: Group learning	Part One + Two
Site 1	n=10, ns	n=7, ns	n=4, ns	n=10, sig	n=7, ns	n=4, ns
Site 2 n=6	ns	ns	sig	ns	sig	sig
Site 3 n=7	sig	-	-	sig	-	-

\* ns: non-significant difference; sig: significant difference

## 5.5 Discussion

The recovery education program provides information about recovery concepts, the in-patient context, and the recovery competency framework in the self-learning part, and provides opportunities for multidisciplinary interactions to solve recovery-related dilemmas in the group-learning part. The current pilot study examined the effectiveness of the recovery educational program at three in-patient mental health research sites. The results suggested that in-patient providers who received the self-learning program improved in recovery knowledge and sense of competency regarding recovery knowledge application. The findings of the group-learning program were encouraging, with participants giving favourable feedback and experiencing satisfaction related to the group learning experience. These

preliminary results support continued efforts to refine the education program and further validate its effectiveness.

### **5.5.1 Overall effectiveness of the education program**

In the evaluation of the self-learning program, participants from site 3 showed significant improvement in both recovery knowledge and sense of recovery knowledge application. A potential explanation for this finding is that participants from site 3 had less pre-intervention exposure to recovery-related education, thus yielding a higher evidence of change. Nevertheless, this association needs to be further assessed. The baseline scores of the RKI for site 1 and 2 were higher (3.91 and 3.94), compared to site 3 (3.74) and two earlier studies, in which the RKI mean scores ranged from 3.14 to 3.89 for a mixture of in-patient and out-patient providers (Meehan & Glover, 2009; Salgado, Deane, Crowe, & Oades, 2010). These high baseline scores might be due to pre-intervention exposure to recovery education and might limit the room for improvement in response to general recovery education. Only one study in the literature, conducted by Peebles et al. in 2009, demonstrated higher RKI scores (4.13-4.31) than this study, but Peebles's study targeted doctorally trained professions in an academic psychiatric department. Such population with a high education level might demonstrate high scores of the RKI. This study results indicated a main effect for increasing recovery knowledge following the self-learning program, especially for those who had less experience of recovery education.

Participants' perceived level of competency regarding the recovery knowledge application increased after the intervention. This means providers felt more confident in their own ability to implement recovery-oriented practices after the self-learning program. In regard to the assessment of the 10 particular dilemmas derived from the competency framework, there was no change of frequency and sense of competency after the self-learning program. Based on these findings, it appears that the self-

learning program has positive effects on recovery knowledge and sense of competency on recovery knowledge application, but not competency in relation to specific dilemmas. It may also be that the measure - Rating Clinical Dilemmas - was not sensitive enough to detect changes.

The design of the group learning intervention involved addressing two recovery-related dilemmas and is meant to assist in translating acquired recovery knowledge into changes in practice. The group program helps providers identify dilemmas to recovery practice and builds success in producing real-life changes through actions. In the Group Learning Program Evaluation, a noteworthy finding was the high rating score (4.12 out of 5) of all group participants' self-perception of their implementation of learning back on the job. The majority of group participants valued the action plans and real implementation in the group. The underpinning strategies to encourage reasoning and action are based on the Appreciative Inquiry (AI) approach. The group participants found it was an enjoyable and practical learning experience to think of what can be done instead of what cannot. As Rubin, Kerrel, and Roberts (2011) in their study of occupational therapy education concluded, both full-time occupational therapy students and teachers enjoyed using the AI approach. AI encourages thinking positively and looking at the situation through an enabling lens. This is especially applicable in mental health settings.

Site 1, at an organizational level, has been promoting recovery for a longer time, compared to the other two sites. Consequently, a few staff from site 1 may view themselves as practicing in a "full" recovery-oriented way, thus limiting their willingness to implement action plans in the group learning program. This might partially explain why the group evaluation of site 1 is lower than site 2. As one of the group members from site 1 said, "We are already recovery-oriented. We have done whatever we can do in the in-patient unit. There is no room for changes". This is an extreme statement but reflects that providers might hold beliefs about recovery-oriented practice that negatively impact practice change and reveals the importance of self-reflection to be addressed in the education program.

To speculate on possible factors influencing group outcomes, those associated with group dynamics such as the stage of group development, patterns of communication, group compositions, and group climate, are some important considerations. In this study, all 6 participants from site 2 completed the total group sessions. The full participation for six weeks may have allowed the group in site 2 to achieve a mature working status characterized by high cohesiveness and commitment to the goals of the group. On the other hand, reaching this level of group maturity may have been compromised in site 1 because of the shorter time of participation and unstable attendance.

### **5.5.2 Study design and methodology**

This study's ability to examine the effectiveness of the educational program was hampered by small sample size. Recruitment and missing data were two major issues in this study. In site 1, there were 35 providers who initially agreed to participate in the self-learning program. But more than two thirds of their post-test data were not collected, even though the researcher and the site liaison used many strategies, such as sending follow-up reminders and asking ward managers for help, to promote the return rate. Future studies may consider more effective ways of implementation, for example, offering incentives for participation. Another perspective related to providers' motivation is their original attitude toward recovery. Those providers who committed to complete the study might support recovery concepts or be interested in knowing more about recovery. Indeed, those who were not recovery-oriented would be the primary target population of this study. This "non recovery-oriented" population might need recovery education but not be motivated or committed to the study.

Time was a primary consideration for the recruitment and scheduling the group learning program. The majority of nursing staff were not able to be released from shifts to participate in the groups. This fact might explain why site 3, which had a high proportion of nursing participants (6 out of 7), was absent for

the group learning program. Although there appeared to be willingness by some providers to attend all group sessions, site 1 and 3 had limited ability to accommodate schedules while at the same time maintaining adequate on-duty staff in the units. Sick leave, staff shortage and turnover, busyness at work, and roster changes were reasons these two sites reported about scheduling difficulties and the negative impact on staff commitment to attend the group sessions over a period of six weeks. Kreiter et al. in their study suggested that, time demands of the continuing education program on the employees must be flexible and kept at a minimum to reach the broadest possible nursing audience (Kreiter, Albanese, Buckwalter, Smith, & Garand, 1999). The increases in the number of participants for further studies can be achieved by getting support at the system level, such as obtaining agreement from managers to support staff's time in participation, or financial compensation for participating in learning sessions.

The lack of participation by psychiatrists was another recruitment issue. Thus the participants of the study did not fully represent the current in-patient workforce. The interprofessional education literature has revealed barriers to engaging doctors in the collaborative learning process (Whitehead, 2007). These barriers included specific powers, status, professional socialization, and decision making responsibility. To develop a successful program to promote recovery and interdisciplinary collaboration, the education program designer must consider effective ways to engage psychiatrists and medical trainees. Whitehead, therefore, suggested that a better understanding of how highly functioning teams currently manage hierarchy and authority and a focus on the development of specific communication and relational skills among team members would be good starting points (Whitehead, 2007).

It would have been beneficial to administer post-test 2 to those who did not participate in the group part but had completed the self-learning part. The data may act as a control group for comparison with those attending the group. Additionally, the study was limited by the use of self-developed

instruments that had not been subject to psychometric testing. Further study requires working on the validation of the self-developed instruments.

As a final point, knowledge gain does not necessarily translate into changes in clinical practice. For example, poor transfer of recovery training into the workplace was found in an Australian study indicating that the key barriers for knowledge transfer included constraints at an institutional level and perceived resistance from patients (Uppal, Oades, Crowe, & Deane, 2010). Future research could be enhanced if outcome measures linked provider knowledge and sense of competency to skill demonstration or behaviour changes in practice, for example, exploring the relationship between the education intervention and the number of recovery-oriented services provided. However, barriers to knowledge translation should be addressed to achieve greater success. With improved patient outcomes as the final purpose for a provider education program, there is also a need to further demonstrate the relationship between provider competency improvement and patient outcomes.

### **5.5.3 Improving the education program**

In the evaluation of the self-learning program, there was an association between improvements in knowledge and previous experience of recovery education. The less recovery training providers had received prior to the study, the higher improvement they had in recovery knowledge. As expected, in-patient providers varied in their level of recovery competency. For some providers, the content of the self-learning program might have been more of a review, whereas for some other providers it's a valuable resource for getting recovery knowledge. There appears to be a need for re-organizing the self-learning program into different learning levels, for instance, for beginner, intermediate, and advanced level, in order to satisfy different providers' needs.



Young et al. (2005) stated that education intervention would be easier to be disseminated if the program is acceptable, feasible, and useful within the clinical context. The self-learning program has incorporated all these features in the design. The majority of participants' feedback was in favour of this self-learning format. They valued "learning on my own time" as an important feature of the program, especially in the busy in-patient context. Many participants stated that they liked the self-learning program with rich recovery information and resources, the computer module, the interactive quizzes, and the most important feature, easy and flexible access. Similarly, O'Shea in her review found that one of the benefits of self-directed learning in nurse education is allowing learner management of the learning process, which has potential to increase learner autonomy and motivation (O'Shea, 2003). Kreiter et al. also suggested that a self-contained program with flexible implementation is likely to achieve greater success (Kreiter, Albanese, Buckwalter, Smith, & Garand, 1999). Other participants' comments about the self learning program included the desire for more case studies, an audio CD, or a video lecture to be featured with the package. Further improvement of the program could incorporate these suggestions to better meet user needs.

Adult learners are goal-oriented, relevancy-oriented, and practical (McAllister, 1997). Education must therefore be grounded in practical experience and actively involve in-patient providers in solving clinical problems. Addressing two clinical dilemmas in the group learning program was meant to demonstrate these principles. In the evaluation of the group learning program, participants appreciated having a chance to solve problems in real situations and to reflect on existing barriers and potential changes. The implementation of the action plans helped participants translate recovery knowledge into real-life practice. Another important feature of the group design is the interdisciplinary interaction. Participants highlighted the benefits of multidisciplinary discussion as they could get input from others, acquire a variety of suggestions, ask for help, and learn more about resources. The group interaction

created a shared vision about recovery within the team members and facilitated clinical implementation based on the recovery vision. The finding about the benefits of the interactive techniques used in the education is consistent with the literature on continuing education and interprofessional education (Daniels & Walter, 2002; Mann, Sargeant, & Hill, 2009; Pollard, Gulbard, Levy, & Gelkopf, 2008). In particular, there is an increase in the emphasis on the effects of facilitating collaborative relationships among mental health professionals in interprofessional education (Priest, Roberts, Dent, Blincoe, Lawton, & Armstrong, 2008; Rolls, Davis, & Coupland, 2002). The study demonstrated that this group design is valuable and applicable for the in-patient providers, while adding more clinical cases may further improve the program.

In summary, the self-learning part providing recovery knowledge and resources, followed by the group learning part which promoted interdisciplinary interaction and translates acquired knowledge into clinical practice, together can be viewed on a continuum of learning to enable in-patient providers to embrace recovery-oriented practice. Further attention can be drawn to the broader dissemination of this education program, as there is a need for training and education of the recovery model in the field (Cleary & Dowling, 2009). The train-the-trainer approach then could be used to train group facilitators who are capable of delivering the group learning program.

#### **5.5.4 Limitations**

Several limitations of the study should be highlighted. The lack of a control group means that some confounding factors, such as the effect of other education or the degree of recovery-oriented culture in the research sites, could not be ruled out in the discussion of improvements. The sample size might be too small to identify important differences. There might have been a recruitment bias at each site. It is possible that more recovery-oriented providers chose to participate in this study, thus resulting in a higher baseline measure of recovery knowledge and sense of general competency. This factor may also limit the

study's ability to detect meaningful changes. Ideally, if the data of the non-respondents were available, the research would be able to compare the characteristics and scores of the participants versus the non-participants to understand potential non-response bias. However, this is a pilot study. The limitations can be mitigated by further study using control groups.

In addition, the outcome measures involve self-report questionnaires. There might be a potential for social desirability bias, for instance, so that participants' self-reports on perceived sense of competency may not truly represent their actual level of competencies. Further validation of the investigator-developed instruments is necessary.

## **5.6 Conclusion**

Implementing recovery-oriented services requires providers with recovery competencies and a willingness to change. This study demonstrates how the development of a recovery training program that bases its content and format on the perceived dilemmas and needs of in-patient providers can result in an effective education program. This is the first known effort to address recovery education in the in-patient setting. The self-learning part of the program has proven to be feasible in the busy in-patient context and demonstrated positive effects on providers' recovery knowledge and sense of competency on recovery knowledge application, especially for those who did not previously access recovery-related education. The group learning part of the program was rated very favourably with evidence of some improvement in recovery competencies. Overall, the recovery education program demonstrates an effective way of enabling in-patient providers to increase recovery-related knowledge, attitudes, skills, and behaviours. The findings support further improvement and validation of the education program. This study represents an important step forward in terms of promoting recovery in in-patient settings.

## Chapter 6

### General Discussion and Conclusion

#### 6.1 Summary of the three phases of the study

This study was comprised of three phases. Phase One, Competency Development, aimed to identify the most salient recovery competencies required of in-patient mental health providers in order to inform the development of an education program and develop a shared understanding of recovery. A qualitative research design including key informant interviews and a literature review, was used. The results indicated that, to practice recovery-oriented services in the in-patient context, providers were faced with tensions related to balancing the medical model with its illness focus and the recovery model with its focus on consumer growth and development. Two conceptual models were developed in this phase. The first one was a tension-practice-consequence model addressing key tensions inherent in delivering recovery-oriented services in the in-patient setting and demonstrating the relationships among these tensions. The second was a process model designed to enable in-patient provider delivery of recovery-oriented services. Based on these two models, a recovery competency framework consisting of eight core competencies with four to ten sub-competencies was developed.

For the identified competencies to be translated into daily practice, a recovery education program was constructed in Phase Two. There are two parts to the education program. Part One, The Self-learning Program, consists of a 72-page user's manual and an interactive DVD lesson for flexible delivery to in-patient providers. The Self-learning Program provides an overview of the recovery concepts, the tension-practice-consequence model, and the recovery competency framework. Part Two, The Group Learning Program, consists of two learning modules, "Encouraging Participation" and "Strength-based Practice," which are constructed to address two real-life dilemmas experienced in in-patient settings and apply the

Appreciative Inquiry approach to manage these dilemmas. A facilitator's toolkit was included with the program to provide guidance and resources for facilitators to deliver the group learning program.

To examine the effectiveness of the recovery education program, a pilot study with a pre-test/post-test design was used. Twenty-six in-patient providers from three tertiary care mental health hospitals were recruited. Outcome measures included the Recovery Knowledge Inventory, the Recovery Knowledge Application Inventory, Rating Clinical Dilemmas, and the Group Learning Program Evaluation. The results showed that participants improved on recovery knowledge and sense of recovery knowledge application after the self-learning program. The evaluation of the group-learning program was positive with participants experiencing satisfaction related to the group learning experience.

This study's three phases involved needs assessment, competency identification, education program development, and program evaluation. These provide a comprehensive process to improve in-patient provider competencies in delivering recovery-oriented services and demonstrate the process of knowledge translation. Both the competency framework and the education program developed in the study are characterized by a context-specific feature, that is, the exploration of how recovery might be implemented in the in-patient context.

## **6.2 Tension-based framework**

In Phase One of the study, the following tensions were identified in regards to providers: discomfort with change and power sharing; negative beliefs about in-patients; and conflicts experienced between risk control and risk management. Tensions identified at the organizational level included heavy workload, lack of support, and the inflexible structure of the in-patient setting. An additional tension was identified in Phase Three. Some participants declared themselves to be already familiar with recovery and claimed to already practice recovery-oriented services. These responses exemplify one of the top ten

concerns about recovery proposed by Davidson; while ideas about recovery have been around for decades in different forms, many providers are unclear about current visions of recovery and/or how their own practices fall short of current recovery concepts (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009). Indeed, the implementation of recovery in the in-patient context is still in its infancy. The tension here is perhaps related to providers' misperceptions about recovery and recovery-oriented practices. The danger is that providers who hold these perceptions may be less likely to self-reflect, and subsequently less likely to change their practice. These misperceptions about recovery echo Davidson's ten concerns that providers might see recovery-oriented services as a burden and non-practical (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009). The recovery education program developed in this study intends to address these ten concerns and change provider attitudes by putting the tensions on the table to encourage dialogue, and delivering a hopeful and empowering message that recovery-oriented practice can be implemented in the in-patient context; and in fact, some forms of recovery-oriented services are already being provided. Such practice is perhaps less likely to devalue professional roles and instead develops a collaborative relationship among all stakeholders.

All tensions proposed in this study are supported by the literature (Alexander & Bowers, 2004; Cleary, 2003; Dorrer & Schinkel, 2008; Smith & Bartholomew, 2006). Dorrer and Schinkel suggested that providers have to recognize the tensions between different opinions and find solutions to reconcile the tensions. Finding a balance between different principles requires that providers have the ability to focus on the patient and his/her recovery (Dorrer & Schinkel, 2008). Tensions have a potential to support organizational change. If providers are enabled to identify the tensions embedded in recovery-oriented practice and view the tensions as learning opportunities to achieve a thorough understanding of recovery, then they can serve as catalysts for change (Krupa & Clark, 2009). Critical to this process is the necessity of reflecting on their daily practice – an important provider competency. The study results support this

point. Participants, in response to the group learning program, expressed appreciation for the chance to reflect on existing barriers and potential changes in real situations.

Moreover, in this study, the Appreciative Inquiry approach proved to be useful in understanding tension-based practice. The fundamental assumptions of the Appreciative Inquiry approach are compatible with recovery concepts. Through communication and interaction in the group learning program, the participants were able to appreciate their current practice, analyze their tensions from a positive perspective, use positive language, create worthy ideals, and actively engage in action plans to reconcile tensions. Applying the Appreciative Inquiry approach, the recovery educational program is strength-based and learner-centered; such features can increase providers' motivation to change and create positive solutions that address their tensions. This study advanced the field by addressing tensions in the competency framework and the education program and applying the Appreciative Inquiry approach as a tool to help providers negotiate tensions embedded in recovery-oriented practice. It is practical in that it helps providers realize the challenges to implementation and offer opportunities to integrate tensions and learn from tensions.

### **6.3 Linking education and practice**

Education is identified as an important strategy for implementing recovery concepts (Jacobson & Curtis, 2000). The development of the recovery competency framework and the recovery education program can launch a dialogue on shared recovery concepts and the linkage between education and practice among in-patient providers. Moreover, evaluation of the education program is necessary so that its strengths and weaknesses can be identified and improvements to the program can be made.

This thesis demonstrates the process of Knowledge Translation from knowledge creation (identification of the recovery competencies) to knowledge implementation (development and

examination of the recovery education program). In Phase One, the recovery competency framework clearly present in-patient providers' competencies required for delivering recovery-oriented services. This framework meets providers' knowledge needs and addresses their tensions in the daily practice. The development of the education program in Phase Two encompasses the activities for knowledge application, and followed by the program evaluation in Phase Three to determine if the application makes the desired changes. Together the three phases represent the Knowledge to Action process (Graham, et al., 2006). This thesis is important in terms of ensuring that recovery knowledge and identified recovery competencies can be transferred into daily practice in the in-patient context. After the refinement of the education program, further endeavor can focus on the last step of the action - sustaining the use of knowledge.

The Kirkpatrick's framework for learning evaluation was used as a guiding framework for the program evaluation at Phase Three of the study. Kirkpatrick's framework consists of four levels of learning evaluation: reaction, learning, behaviour, and results. The findings of Phase Three indicated that the education program demonstrates effectiveness according to Kirkpatrick's level 1 (reaction), level 2 (learning), and level 3 (behaviour). It should be noted that level 3, behaviour evaluation, was evaluated using participants' self-report in this study. Level 1 reflected the participants' immediate reactions to the program materials, format, leader, setting, and learning activities. Good satisfaction ratings were found in this study which indicated participants' reflection on the positive learning experience. Such good satisfaction means learning occurred at the relevant and meaningful domains and triggers the learners for becoming aware of the tensions. At level 2, participants' improvement on the Recovery Knowledge Inventory determined the extent to which learning had occurred. Such quantification of the results supports the education program, although there is still no guarantee of application of knowledge on the job. Kirkpatrick proposed five conditions for behaviour changes to occur at level 3: a desire to change, the



necessary knowledge and skills, a right climate in the working environment, encouragement and help, and the reward for changing (Kirkpatrick & Kirkpatrick, 2010). The first two conditions can be achieved through the education program while the third to fifth conditions require sustained support and commitment at the institutional level. Kirkpatrick's framework is used for training evaluation; however, it does not inform the ways to proceed to the next levels of learning. Realizing the implementation of recovery in practice will likely depend on a second framework guiding the process of knowledge application and behavior changes. Moreover, the transfer of recovery learning into daily practice will not occur without system support. Therefore, recovery must be closely aligned with the visions and goals of the institutions in order to support the changing climate and amplify the learning effects.

Influencing the practice of professionals in interprofessional contexts such as the in-patient setting requires focused efforts that go beyond education or training of service providers. For example, the "Interprofessional Education for Collaborative Patient-Centred Practice" (IECPCP) framework analyses the factors that affect a professional's capacity to become a competent provider, and describes three levels of attention required: : the micro (teaching) level, the meso (institutional) level, and the macro (system) level (D'Amour & Oandasan, 2005). The micro level factors involve the learning context and the faculty development. The recovery education program developed in this study applies both self-learning and group-learning strategies in order to meet the needs of busy in-patient providers, while at the same time it provides opportunities for interprofessional interaction in the group setting. The results of this study support that the learning context using these two strategies is well suited to in-patient providers. In terms of faculty development, the training of group facilitators is essential for the effective delivery of the group learning program in order to integrate different opinions, enable strengths-based and solution-focused ideas, and facilitate interprofessional collaboration.

The meso level factors include leadership, resources, and administrative process in an institution. The importance of administrator support in education was identified in Phase Three of the study, as administrators have the power to decide the institutional agenda and provide resources. In addition, when linking the education to practice, the IECPCP framework emphasizes that the context of the institution exercises significant influence on knowledge application. In this case, the more that recovery orientation is promoted in an institution, the higher possibility the recovery knowledge might be implemented. As a result, administrators' leadership and institutional recovery-oriented culture and process are critical factors that contribute to the success of the education program.

Finally, the macro level factors are related to the recovery-oriented mental health system. The efforts and issues of the mental health system transformation toward a recovery orientation have been reviewed in Chapter Two. In Canada, a shared vision for mental health recovery has been created. Policies about the promotion of recovery were developed at various levels of government. A notable finding of Piat et al.'s study is that Canadian decision makers agree that "recovery training needs to occur at all levels of the system" (Piat, Sabetti, & Bloom, 2010, p. 174). Such declaration at the system level is encouraging but there needs to be reflection on structural and financial integration to ensure the successful implementation of programs, for instance, providing and securing funding for recovery education. Other system level concerns include the structure of mental health professions. For example, the professional organizations or colleges have a role in impacting professional practices and education. Therefore, one of the strategies to promote the recovery education program is to get the support of professional colleges or associations, such as the College of Occupational Therapists of Ontario and the College of Nurses of Ontario. Lastly, accreditation of mental health institutions/organizations may also have a powerful impact if the promotion of recovery concepts is incorporated into the accreditation evaluation criteria. For example, in 2005, the new standards of the Comprehensive Accreditation Manual

for Behavioral Health Care (CAMBHC) from the Joint Commission on Accreditation of Healthcare Organizations in the USA addressed the recovery vision and recovery-oriented approach to working with people with serious mental illness (Cesare-Murphy, 2005). One of these standards requires the involvement of peer support in the treatment plans and the education and training for peer workers. Although these standards are mostly applied to services offered in community settings, the development of the accreditation standards that recognize recovery and the transformation of the mental health system is one important step forward at the system level. Further endeavours could focus on the inclusion of provider recovery education and in-patient recovery-oriented practice in the accreditation criteria.

The three levels of factors - micro, meso, macro - are dynamic and interactional (D'Amour & Oandasan, 2005). To effectively implement the recovery education program and amplify its effectiveness on practice and patient outcomes, the micro, meso, and macro level of support must be aligned for the in-patient context and must put patients at the centre of integration. Although this study mainly focused on the micro level, the meso and macro level of concerns need to be addressed for further promotion of provider recovery competencies.

#### **6.4 Implication for further research**

This study identified competencies required for in-patient recovery-oriented practice and provided initial empirical support for the effectiveness of the recovery education program designed to teach these competencies. The next steps can focus on the following:

1. Validation of the recovery competency framework: Refining the content validity of the two models developed in Phase One of the study and defining the competencies along with criterion measures may further improve the competency framework. Future research can seek to answer the following questions: How well do the targeted competencies represent the requirements of recovery-oriented in-patient

services? How acceptable are the competencies to in-patient providers? What dimensions of recovery are missing in the framework? and how might the recovery competency framework be extended to other in-patient contexts?

2. Refinement of the format and content of the education program: Based on the feedback and comments from the participants in Phase Three of the study, the education program can be refined in terms of adding more group learning modules and case studies, adding video lectures, involving consumer presentations, and reorganizing the content to different levels of difficulty. The generalizability of the recovery education program to other in-patient contexts, such as emergency rooms and forensic wards, also needs further attention.

3. Evaluation of the education program: The pilot study conducted in Phase Three provided preliminary evidence supporting the feasibility of the education program in the field. In the future, more rigorous research methods, such as a mixed evaluation design involving a randomized controlled trial and a qualitative investigation, can be used to provide more powerful evidence regarding program effectiveness.

## **6.5 Conclusion**

This thesis described the development of the recovery competency framework and the innovation of the recovery education program designed to meet in-patient providers' needs. The important role in-patient providers play in promoting recovery was highlighted through the identification of competencies and the implementation of the education program. The study results find the education program to be effective in terms of an increase of recovery knowledge and sense of competencies regarding knowledge application. This thesis contributes to scholarship by addressing recovery competency for in-patient providers and demonstrating an effective education program specifically targeted to the in-patient context. The study results advance the field by the development of the recovery competency framework and

related education tool for improving competencies. The application of the Appreciative Inquiry approach in the education program is innovative in the field and worthy for further exploration. People in recovery may access different forms of services in different contexts. Directing the attention of the recovery movement from community contexts to in-patient contexts can improve the continuity of recovery-oriented service delivery. The broad dissemination of the study results and the recovery education program is necessary in the future to help the promotion of recovery-oriented services in the in-patient context.

## References

- Alexander, J., & Bowers, L. (2004). Acute psychiatric ward rules: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 11, 623-631.
- Anthony, W. A. (2000). A recovery-oriented service system: Setting some system-level standards. *Psychiatric Rehabilitation Journal*, 23, 159-168.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16, 11-23.
- Ashcraft, L., & Anthony, W. A. (2008). Addressing resistance to recovery. *Behavioral Healthcare*, 28, 10-11.
- Australian Health Ministers. (2003). *National Mental Health Plan 2003-2008*. Canberra: Australian Government.
- Axiom Market Research and Consultancy. (2006). *Evaluation of recovery based training for trainers pilot*. Scotland: The Scottish Recovery Network.
- Barbic, S., Krupa, T., & Armstrong, I. (2009). A randomized controlled trial of the effectiveness of a modified Recovery Workbook Program: Preliminary findings. *Psychiatric Services*, 60, 491-497.
- Barker, P. J. (2001). The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, 8, 233-240.
- Barker, P. J., & Buchanan-Barker, P. (2010). The Tidal Model of Mental Health Recovery and reclamation: Application in acute care setting. *Issues in Mental Health Nursing*, 31, 171-180.
- Bartholomew, T., & Kensler, D. (2010). Illness management and recovery in state psychiatric hospitals. *American Journal of Psychiatric Rehabilitation*, 12, 105-125.
- Bedregal, L. E., O'Connell, M., & Davidson, L. (2006). The Recovery Knowledge Inventory: Assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric Rehabilitation Journal*, 30, 96-103.
- Bonney, S., & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, 15, 140-153.
- Bopp, J. H., Ribble, D. J., Cassidy, J. J., & Markoff, R. A. (1996). Re-engineering the state hospital to promote rehabilitation and recovery. *Psychiatric Services*, 47, 697-701.

- Brimblecombe, N., Tingle, A., & Murrells, T. (2007). How mental health nursing can best improve service users' experiences and outcomes in inpatient settings: responses to a national consultation. *Journal of Psychiatric and Mental Health Nursing*, 14, 503-509.
- Brookes, N., Murata, L., & Tansey, M. (2008). Tidal Waves: Implementing a new model of mental health recovery and reclamation. *The Canadian Nurse*, 104, 23-27.
- Buchanan-Barker, P., & Barker, P. J. (2008). The Tidal Commitments: extending the value base of mental health recovery. *Journal of Psychiatric and Mental Health Nursing*, 15, 93-100.
- Cairns, R., Maddock, C., Buchanan, A., David, A., Hayward, P., Richardson, G., et al. (2005). Prevalence and predictors of mental incapacity in psychiatric in-patients. *British Journal of Psychiatry*, 187, 379-385.
- Campbell, J., & Gallagher, R. (2007). *A Literature Review and Documentary Analysis on Recovery Training in Mental Health Practice*. Glasgow, UK: NHS Education for Scotland / Scottish Recovery Network.
- Campbell-Orde, T., Chamberlin, J., Carpenter, J., & Leff, H. S. (2005). *Measuring the Promise: A Compendium of Recovery Measures, Volume II*. Cambridge, MA: Human Services Research Institute.
- Canadian Institute for Health Information. (2005). *Inpatient hospitalizations and Average Length of Stay trends in Canada, 2003-2004 and 2004-2005*. Ottawa, Ontario: Canadian Institute for Health Information.
- Carpenter, J. (2002). Mental health recovery paradigm: Implications for social work. *Health & Social Work*, 27, 86-94.
- Cesare-Murphy, M. (2005). Recognizing the recovery perspective: New Joint Commission standards address this emerging approach to service delivery. *Behavioral Health Management*, Nov/Dec, 15-16.
- Chickwama, A. (2007). First experience. In M. Hardcastle, D. Kennard, S. Grandison, & L. Fagin, *Experiences of mental health in-patient care: Narratives from service users, carers and professionals* (pp. 127-132). Hove, East Sussex: Routledge.
- Chinman, M., Kloud, B., O'Connell, M., & Davidson, L. (2002). Service providers' views of psychiatric mutual support groups. *Journal of Community Psychology*, 30, 349-366.
- Cleary. (2003). The challenges of mental health care reform for contemporary mental health nursing practice: Relationships, power and control. *International Journal of Mental Health Nursing*, 12, 139-147.

- Cleary. (2004). The realities of mental health nursing in acute inpatient environments. *International Journal of Mental Health Nursing*, 13, 53-60.
- Cleary, A., & Dowling, M. (2009). Knowledge and attitudes of mental health professionals in Ireland to the concept of recovery in mental health: a questionnaire survey. *Journal of Psychiatric and Mental Health Nursing*, 16, 539-545.
- Cole, M. B. (2005). Group leadership: Cole's seven steps. In M. B. Cole, *Group dynamics in occupational therapy* (pp. 3-23). Thorofare, NJ: SLACK Incorporated.
- Cook, J. A., Copeland, M. E., Jonikas, J. A., Hamilton, M. M., Razzano, L. A., Grey, D. D., et al. (2011). Results of a randomized controlled trial of mental illness self-management using Well Recovery Action Planning. *Schizophrenia Bulletin*, doi:10.1093/schbul/sbr012, First published online March 14.
- Cook, N. R., Phillips, B. N., & Sadler, D. (2005). The Tidal Model as experienced by patients and nurses in a regional forensic unit. *Journal of Psychiatric and Mental Health Nursing*, 12, 536-540.
- Cooperrider, D., Whitney, D., & Stavros, J. M. (2003). *Appreciative inquiry handbook: The first in a series of AIworkbooks for leaders of change*. Bedford Heights, OH: Lakeshore Communications, Inc.
- Copeland, M. E. (2001). Wellness Recovery Action Plan: A system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings. *Occupational Therapy in Mental Health*, 17, 127-150.
- Copeland, M. E. (2011). *WRAP and recovery books*. Retrieved Oct 4, 2011, from WRAP and recovery books: <http://www.mentalhealthrecovery.com/>
- Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2008). *Principles and practice of psychiatric rehabilitation: An empirical approach*. New York, NY: The Guilford Press.
- Coursey, R. D., Curtis, L., Marsh, D. T., Campell, J., Harding, C., Spaniol, L., et al. (2000). Competencies for direct service staff members who work with adult with severe illnesses: Specific knowledge, attitudes, skills, and bibliography. *Psychiatric Rehabilitation Journal*, 23, 378-392.
- Crowe, T. P., Deane, F. P., Oades, L. G., Gaputi, P., & Morland, K. G. (2006). Effectiveness of a collaborative recovery training program in Australia in promoting positive views about recovery. *Psychiatric Services*, 57, 1497-1500.
- Curran, V., Ungar, T., & Prauzé, E. (2006). *Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators*. Retrieved April 20, 2010, from Canadian Collaborative Mental Health Initiative:



[http://www.ccmhi.ca/en/products/toolkits/documents/EN\\_Strengtheningcollaborationthroughinterprofessionaleducation.pdf](http://www.ccmhi.ca/en/products/toolkits/documents/EN_Strengtheningcollaborationthroughinterprofessionaleducation.pdf)

- D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care*, May, 8-20.
- Daniels, A. S., & Walter, D. A. (2002). Current issues in continuing education for contemporary behavioral health practice. *Administration and Policy in Mental Health*, 29, 359-376.
- Davidson, L. (2005). Recovery, self-management and the expert patient: Changing the culture of mental health from a UK perspective. *Journal of Mental Health*, 14, 25-35.
- Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16, 459-470.
- Davidson, L., & White, W. (2007). The concept of recovery as an organizing principles for integrating mental health and addiction services. *The Journal of Behavioral Health Services & Research*, 34, 109-120.
- Davidson, L., Andres-Hyman, R., Bedregal, L., Tondora, J., Fry, J., & Kirk, T. A. (2008). From "double trouble" to "dual recovery":integrating models of recovery in addition and mental health. *Journal of Dual Diagnosis*, 4, 273-290.
- Davidson, L., Borg, M., Marin, I., Topor, A., Mezzina, R., & Sells, D. (2005). Processes of recovery in serious mental illness: Findings from a multinational study. *American Journal of Psychiatric Rehabilitation*, 8, 177-201.
- Davidson, L., Tondora, J., & O'Connell, M. J. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*, 32, 23-31.
- Davidson, L., Tondora, J., Lawless, M. S., O'Conne, M. J., & Rowe, M. (2009). The recovery movement: Implications for practice. In L. Davidson, J. Tondora, M. S. Lawless, M. J. O'Conne, & M. Rowe, *A practical guide to recovery-oriented practice: Tools for transforming mental health care* (pp. 1-32). New York, NY: Oxford University Press, Inc.
- Davidson, L., Tondora, J., Lawless, M. S., O'Connell, M. J., & Rowe, M. (2009). A model of being in recovery as a foundation for recovery-oriented practice. In L. Davidson, J. Tondora, M. S. Lawless, M. J. O'Connell, & M. Rowe, *A practical guide to recovery-oriented practice* (pp. 33-61). New York, NY: Oxford University Press.
- Davidson, L., Tondora, J., Lawless, M. S., O'Connell, M. J., & Rowe, M. (2009). The top 10 concerns about recovery. In L. Davidson, J. Tondora, M. S. Lawless, M. J. O'Connell, & M. Rowe, *A practical guide to recovery-oriented practice* (pp. 62-88). New York, NY: Oxford University Press, Inc.

- Davidson, O'Connell, M. J., Tondora, J., Staeheli, M., & Evans, A. (2005). Recovery in serious mental illness: Paradigm shift or shibboleth? In L. Davidson, C. Harding, & L. Spaniol, *Recovery from severe mental illness: Research evidence and implications for practice, Volume 1* (pp. 5-26). Boston, MA: Center for Psychiatric Rehabilitation.
- Davidson, O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 57*, 640-645.
- Deegan, P. E. (2001). Recovery as a self-directed process of healing and transformation. *Occupational Therapy in Mental Health, 17*, 5-21.
- Dewing, J., & Traynor, V. (2005). Admiral nursing competency project: Practice development and action research. *Journal of Clinical Nursing, 14*, 695-703.
- Dewis, S., & Harrison, M. (2008). Engaging the disengaged: Practising in acute in-patient settings. In E. A. McKay, C. Craik, K. H. Lim, & G. Richards, *Advancing occupational therapy in mental health practice* (pp. 51-62). Oxford, UK: Blackwell Publishing Ltd.
- Doherty, I., Craig, T., Attafua, G., Boocock, A., & Jamieson-Craig, R. (2004). The consumer-employee as a member of Mental Health Assertive Outreach Team: II. Impressions of consumer-employees and other team members. *Journal of Mental Health, 13*, 71-81.
- Dorrer, N., & Schinkel, M. (2008). How do we define the skills and attributes of recovery-focused mental health practice? Toward recovery competencies. *Mental Health Today*, Feb, 30-33.
- Doughty, C., Tse, S., Duncan, N., & McIntyre, L. (2008). The Wellness Recovery Action Plan (WRAP): workshop evaluation. *Australasian Psychiatry, 16*, 450-456.
- Duggins, R. (2007). Feeling helpness. In M. Hardcastle, D. Kennard, S. Grandison, & L. Fagin, *Experiences of mental health in-patient care* (pp. 117-120). Hove, East Sussex: Routledge.
- England Department of Health. (2003). *Building on the best. Choice, responsiveness and equity in the NHS*. London: Stationery Office.
- England Department of Health. (2005). *Creating a patient-led NHS. Delivering the NHS improvement plan*. London: National Health Service.
- English, T. (2002). *Negotiation as tension management: A model for business and other international transactions*. Adelaide, Australia: School of Commerce, Flinders University.
- Fagin, L. (2007). Commentaries on "Feeling helpness". In M. Hardcastle, D. Kennard, S. Grandison, & L. Fagin, *Experiences of mental health in-patient care: Narratives from service users, carers and professionals* (pp. 117-126). Hove, East Sussex, UK: Routledge.

- Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal*, 41, 141-158.
- Final Report of the Provincial Forum of Mental Health Implementation Task Forces Chairs. (2002). *THE TIME IS NOW: Themes and recommendations for mental health reform in Ontario*. Retrieved 10 31, 2011, from Ontario Ministry of Health and Long-term Care: [http://www.health.gov.on.ca/english/providers/pub/mhitf/provincial\\_forum/provincial\\_forum.pdf](http://www.health.gov.on.ca/english/providers/pub/mhitf/provincial_forum/provincial_forum.pdf)
- Firn, M. (2008). Engagement within the care planning process. In A. Hall, M. Wren, & S. Kirby, *Care planning in mental health: Promoting recovery* (pp. 136-151). Oxford, UK: Blackwell Publishing Ltd.
- Fisher, D. B. (2008). Promoting recovery. In T. Stickley, & T. Basset, *Learning about mental health practice* (pp. 119-139). West Sussex, England: John Wiley & Sons Ltd.
- Forchuk, C., & Reynolds, W. (2001). Clients' reflections on relationships with nurses: Comparisons from Canada and Scotland. *Journal of Psychiatric and Mental Health Nursing*, 8, 45-51.
- Freeth, D., Hammick, M., Reeves, S., Koppel, I., & Barr, H. (2005). *Effective interprofessional education: Development, delivery & evaluation*. Oxford, UK: Blackwell Publishing Ltd.
- Fujita, E., Kato, D., Kuno, E., Suzuki, Y., & Uchiyama, S. (2010). Implementing the illness management and recovery program in Japan. *Psychiatric Services*, 61, 1157-1161.
- Fukui, S., Starnino, V. R., Susana, M., Davidson, L. J., Cook, K., Rapp, C. A., et al. (2011). Effect of Wellnwss Recovery Action Plan (WRAP) participation on psychiatric symptoms, sense of hope, and recovery. *Psychiatric Rehabilitation Journal*, 34, 214-222.
- Gaberson, K. B., & Oermann, M. H. (2010). *Clinical teaching strategies in nursing, 3rd ed.* New York, NY: Springer Publishing Company.
- Gaff, C. L., Aitken, M., Flouris, A., & Metcalfe, S. A. (2007). A model for the development of genetics education programs for health professionals. *Genetics in Medicine*, 9, 451-457.
- Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *Health Services Research*, 8, 92-103.
- Glasby, J., & Lester, H. (2005). On the inside: A narrative review of mental health inpatient services. *British Journal of Social Work*, 35, 863-879.
- Goodwin, A. M., & Gore, V. (2000). Managing the stresses of nursing people with severe and enduring mental illness: A psychodynamic observation study of a long-stay psychiatric ward. *British Journal of Medical Psychology*, 73, 311-325.

- Goodwin, I., Holmes, G., Newnes, C., & Waltho, D. (1999). A qualitative analysis of the views of inpatient mental health service users. *Journal of Mental Health*, 8, 43-54.
- Gordon, W., Morton, T., & Brooks, G. (2005). Launching the Tidal Model: evaluating the evidence. *Journal of Psychiatric and Mental Health Nursing*, 12, 703-712.
- Graham, I. D., Logan, J., Harrison, M. B., Straus, S. E., Tetroe, J., Caswell, W., et al. (2006). Lost in knowledge translation: Time for a map? *The Journal of Continuing Education in the Health Professions*, 26, 13-24.
- Grausgruber, A., Meise, U., Katschnig, H., Schony, W., & Fleischhacker, W. W. (2007). Patterns of social distance towards people suffering from schizophrenia in Austria: A comparison between the general public, relatives and mental health staff. *Acta Psychiatrica Scandinavica*, 115, 310-319.
- Hasson-Ohayon, I., Roe, D., & Kravetz, S. (2007). A randomized controlled trial of effectiveness of the illness management and recovery program. *Psychiatric Services*, 58, 1461-1466.
- Hoge, M. A., Tondora, J., & Marrelli, A. F. (2005). The fundamentals of workforce competency: Implications for behavioural health. *Administration and Policy in Mental Health*, 32, 509-531.
- Howard, P. B., El-Mallakh, P., Rayens, M. K., & Clark, J. J. (2003). Consumer perspectives on quality of inpatient mental health services. *Archives of Psychiatric Nursing*, 5, 205-217.
- Hummelvoll, J. K., & Severinsson, E. I. (2001). Imperative ideals and the strenuous reality: Focusing on acute psychiatry. *Journal of Psychiatric and Mental Health Nursing*, 8, 17-24.
- Jacobson, N. (2001). Experiencing recovery: A dimensional analysis of recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 248-256.
- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal*, 23, 333-341.
- Jensen, L. W., & Wadkins, T. A. (2007). Mental health success stories: Finding paths to recovery. *Issues in Mental Health Nursing*, 28, 325-340.
- Johansson, H., & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Science*, 17, 339-346.
- Johansson, I. M., Skärsäter, I., & Danielson, E. (2006). The health-care environment on a locked psychiatric ward: An ethnographic study. *International Journal of Mental Health Nursing*, 15, 242-250.

- Jorm, A. F., Korten, A. E., Jacomb, P. A., & Christensen, H. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33, 77-83.
- Kelly, M., Lamont, S., & Brunero, S. (2010). An occupational perspective of the recovery journey in mental health. *British Journal of Occupational Therapy*, 73, 129-135.
- Kemmis, S., & McTaggart, R. (2000). Participatory action research. In N. K. Denzin, & Y. S. Lincoln, *Handbook of qualitative research* (pp. 567-605). Thousand Oaks, CA: Sage Publications, Inc.
- Kennard, D., Fagin, L., Hardcastle, M., & Grandison, S. (2007). Things you can do to make in-patient care a better experience. In M. Hardcastle, D. Kennard, S. Grandison, & L. Fagin, *Experiences of mental health in-patient care: Narratives from services users, carers and professionals* (pp. 205-207). Hove, East Sussex: Routledge.
- Kirby, M., & Keon, W. J. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Ottawa: Senate Standing Committee on Social Affairs, Science and Technology.
- Kirkpatrick, D. L., & Kirkpatrick, J. D. (2006). *Evaluating training programs: The four levels. (3rd ed.)*. San Francisco, CA: Berrett-Koehler Publishers, Inc.
- Kirkpatrick, D. L., & Kirkpatrick, J. D. (2010). *Evaluating training programs: The four levels. (4th ed.)*. San Francisco, CA: Berrett-Koehler Publishers, Inc.
- Kreiter, C. D., Albanese, M. A., Buckwalter, K. C., Smith, M., & Garand, L. (1999). The effects of attrition on implementing and evaluating a mental health continuing education program for nursing personnel in long-term care facilities. *The Journal of Continuing Education in Nursing*, 3, 100-104.
- Krupa, T., & Clark, C. (2009). Using tensions in practice to promote the integration of treatment and rehabilitation in a recovery-oriented system. *Canadian Journal of Community Mental Health*, 28, 47-59.
- Lafferty, S., & Davidson, R. (2006). Putting the person first. *Mental Health Today*, 31-33.
- Lal, S. (2010). Prescribing recovery as the new mantra for mental health: Does one prescription serve all? *Canadian Journal of Occupational Therapy*, 77, 82-89.
- Liberman. (2008). *Recovery from disability: Manual of Psychiatric rehabilitation*. Arlington, VA: American Psychiatric Publishing, Inc.
- Liberman, R. P., Kopelowicz, A., Ventura, J., & Gutkind, D. (2002). Operational criteria and factors related to recovery from schizophrenia. *International Review of Psychiatry*, 14, 256-272.

- Lloyd, C., Waghorn, G., & Williams, P. L. (2008). Conceptualising recovery in mental health rehabilitation. *British Journal of Occupational Therapy*, 71, 321-328.
- Mann, K., Sargeant, J., & Hill, T. (2009). Knowledge translation in interprofessional education: what difference does interprofessional education make to practice? *Learning in Health and Social Care*, 8, 154-164.
- Marrelli, A. F., Tondora, J., & Hoge, M. A. (2005). Strategies for developing competency models. *Administration and Policy in Mental Health*, 32, 533-561.
- Marshall, S. L., Oades, L. G., & Crowe, T. P. (2009). Mental health consumers' perceptions of receiving recovery-focused services. *Journal of Evaluation in Clinical Practice*, 15, 654-659.
- Martin, N., & Johnston, V. (2007). *A time for action: Tackling stigma and discrimination*. Ottawa, ON: Mental Health Commission of Canada.
- McAllister, L. (1997). An adult learning framework for clinical education. In L. McAllister, M. Lincoln, S. McLeod, & D. Maloney, *Facilitating learning in clinical settings* (pp. 1-26). Cheltenham, UK: Nelson Thornes Ltd.
- McAllister, L. (1997). An adult learning framework for clinical education. In L. McAllister, M. Lincoln, S. McLeod, & D. Maloney, *Facilitating learning in clinical settings* (pp. 1-26). Cheltenham, UK: Nelson Thornes Ltd.
- McCann, T. V., Baird, J., & Lu, S. (2008). Mental health professionals' attitudes towards consumer participation in inpatient units. *Journal of Psychiatric and Mental Health Nursing*, 15, 10-16.
- McCracken, S. G., & Corrigan, P. W. (2008). Motivational interviewing for medication adherence in individuals with schizophrenia. In H. Arkowitz, H. A. Westra, W. R. Miller, & S. Rollnick, *Motivational interviewing in the treatment of psychological problems* (pp. 249-276). New York, NY: The Guilford Press.
- McVanel, S., Younger, J., Doyle, W., & Kirkpatrick, H. (2006). Implementing program-wide awareness about recovery in a large mental health and addictions program. *Psychiatric Rehabilitation Journal*, 30, 141-144.
- Mead, S., & Copeland, M. E. (2000). What recovery means to us: Consumers' perspective. *Community Health Journal*, 36, 315-328.
- Meehan, T. J., King, R. J., Beavis, P. H., & Robinson, J. D. (2008). Recovery-based practice: do we know what we mean or mean what we know? *Australian and New Zealand Journal of Psychiatry*, 42, 177-182.

- Meehan, T., & Glover, H. (2009). Using the Recovery Knowledge Inventory (RKI) to assess the effectiveness of a consumer-led recovery training program for service providers. *Psychiatric Rehabilitation Journal*, 32, 223-226.
- Mental Health Commission Ireland. (2008). *A recovery approach within the Irish mental health services: A framework for development*. Dublin: Mental Health Commission.
- Mental Health Commission Ireland. (2006). *Mental Health Commission Strategic Plan 2006 – 2008*. Dublin: Mental Health Commission.
- Mental Health Commission of Canada. (2009). *Toward recovery and well-being: A framework for a mental health strategy in Canada*. Calgary, Alberta: Mental Health Commission of Canada.
- Merryman, M. B., & Riegel, S. K. (2007). The recovery process and people with serious mental illness living in the community: An occupational therapy perspective. *Occupational therapy in Mental Health*, 23, 51-73.
- Morrison, B., & Lilford, R. (2001). How can action research apply to health services? *Qualitative Health Research*, 11, 436-449.
- Moyle, W. (2003). Nurse-patient relationship: A dichotomy of expectation. *International Journal of Mental Health Nursing*, 12, 103-109.
- Mueser, K. T., Corrigan, P. W., Hilton, D. W., Tanzman, B., Schaub, A., Gingerich, S., et al. (2002). Illness management and recovery: A review of the research. *Psychiatric Services*, 53, 1272-1284.
- Mullen, A. (2009). Mental health nurses establishing psychosocial interventions within acute inpatient settings. *International Journal of Mental Health Nursing*, 18, 83-90.
- Mulvale, G. (2005, May 27). *Health Human Resources Planning for Mental Health Services: Lessons Learned from a Review of Experiences in the U.K., Australia and New Zealand*. Retrieved February 26, 2010, from The Canadian Employment Research Forum: [http://www.cerf.mcmaster.ca/conferences/May2005/mulvale\\_cerf05.pdf](http://www.cerf.mcmaster.ca/conferences/May2005/mulvale_cerf05.pdf)
- Mulvale, G. (2005, May 27). *Health Human Resources Planning for Mental Health Services: Lessons Learned from a Review of Experiences in the U.K., Australia and New Zealand*. Retrieved February 26, 2010, from The Canadian Employment Research Forum: [http://www.cerf.mcmaster.ca/conferences/May2005/mulvale\\_cerf05.pdf](http://www.cerf.mcmaster.ca/conferences/May2005/mulvale_cerf05.pdf)
- Mulvale, G., & Bartram, M. (2009). Recovery in the Canadian context: Feedback on the framework for mental health strategy development. *Canadian Journal of Community Mental Health*, 28, 7-15.
- Mulvale, G., Abelson, J., & Goering, P. (2007). Mental health service delivery in Ontario, Canada: how do policy legacies shape prospects for reform? *Health Economics, Policy and Law*, 2, 363-389.

- New Zealand Mental Health Commission. (2001). *Recovery competencies for New Zealand mental health workers*. Retrieved February 2, 2008, from Mental Health Commission:  
[http://www.mhc.govt.nz/publications/2001/Recovery\\_Competencies.pdf](http://www.mhc.govt.nz/publications/2001/Recovery_Competencies.pdf)
- NHS Education for Scotland. (2010). *A Capability Framework for Working in Acute Mental Health Care*. Retrieved April 15, 2010, from NHS Education for Scotland:  
<http://www.nes.scot.nhs.uk/mentalhealth/publications/documents/AcuteMentalHealthFINAL.pdf>
- NHS Education for Scotland. (2007b). *Realising recovery: a national framework for learning and training in recovery focused practice*. Retrieved February 24, 2010, from SCOTTISH RECOVERY NETWORK:  
<http://www.nes.scot.nhs.uk/mentalhealth/publications/documents/RealisingRecoveryFrameworkDocumentFINAL.pdf>
- NHS Education for Scotland. (2008). *Realising recovery: learning materials*. Retrieved February 24, 2010, from SCOTTISH RECOVERY NETWORK:  
<http://www.nes.scot.nhs.uk/mentalhealth/publications/documents/13875-NES-MentalHealth-Allmodules.pdf>
- NHS Education for Scotland. (2007a, April). *Values Based Practice: The 10 Essential Shared Capabilities for Mental Health Practice Learning Materials (Scotland)*. Retrieved February 24, 2010, from NHS Education for Scotland:  
<http://www.nes.scot.nhs.uk/mentalhealth/publications/documents/module2-The10EssentialSharedCapabilities.pdf>
- Noordsy, D. L., Torrey, W. C., Mead, S., Brunette, M., Potenza, D., & Copeland, M. E. (2000). Recovery-oriented psychopharmacology: Redefining the goals of antipsychotic treatment. *Journal of Clinical Psychiatry*, 61(suppl 3), 22-29.
- NYAPRS Collective. (2011). *Collective Training and Technical Assistance*. Retrieved May 11, 2011, from New York Association of Psychiatric Rehabilitation Services:  
<http://www.nyaprs.org/services-transformation/collective/training.cfm>
- Oades, L., Deane, F., Crowe, T., Lambert, W. G., Kavanagh, D., & Lloyd, C. (2005). Collaborative recovery: An integrative model for working with individuals who experience chronic and recurring mental illness. *Psychiatric Services*, 279-284.
- Ochocka, J., Nelson, G., & Janzen, R. (2005). Moving forward: Negotiating self and external circumstances in recovery. *Psychiatric Rehabilitation Journal*, 28, 315-322.
- Oeye, C., Bjelland, A. K., Skorpen, A., & Anderssen, N. (2009). User participation when using milieu therapy in a psychiatric hospital in Norway: A mission impossible? *Nursing Inquiry*, 16, 287-296.
- O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers*. Retrieved Oct. 28, 2009, from Mental Health Commission of New Zealand :



[http://www.mhc.govt.nz/users/Image/Resources/2001%20Publications/RECOVERY\\_COMPETENCIES.PDF](http://www.mhc.govt.nz/users/Image/Resources/2001%20Publications/RECOVERY_COMPETENCIES.PDF)

Ohio Department of Mental health. (1999). *Emerging Best Practice in Mental Health Recovery Process*. Retrieved February 23, 2010, from The Hamilton County Mental Health and Recovery Services Board recovery website: [http://www.mhrecovery.com/best\\_practices.htm](http://www.mhrecovery.com/best_practices.htm)

Ontario Ministry of Health and Long-Term Care. (1999). *Making It Happen: Implementation plan for mental health reform*. Toronto, ON: Ontario Ministry of Health and Long-Term Care.

O'Shea, E. (2003). Self-directed learning in nurse education: a review of literature. *Journal of Advanced Nursing*, 43, 62-70.

Patton, M. Q. (2002). *Qualitative research & evaluation methods*. Thousand Oaks, CA: Sage Publications Ltd.

Peebles, S. A., Mabe, P. A., Fenley, G., Buckley, P. F., Bruce, T. O., Narasimhan, M., et al. (2009). Immersing practitioners in the recovery model: An educational program evaluation. *Community Mental Health Journal*, 239-245.

Pejlert, A., Asplund, K., Gilje, F., & Norberg, A. (1998). The meaning of caring for patients on a long-term psychiatric ward as narrated by formal care providers. *Journal of Psychiatric and Mental Health Nursing*, 5, 255-264.

Pennsylvania Department of Public Welfare, O. o. (2005, 11). *A CALL FOR CHANGE: Toward a recovery-oriented mental health service system for adults*. Retrieved March 12, 2010, from Pennsylvania Department of Public Welfare: <http://www.dpw.state.pa.us/Resources/Documents/Pdf/Publications/ACallForChange.pdf>

Piat, M., & Sabetti, J. (2009). The development of a recovery-oriented mental health system in Canada: What the experience of commonwealth countries tells us. *Canadian Journal of Community Mental Health*, 28, 17-33.

Piat, M., Sabetti, J., & Bloom, D. (2010). The transformation of mental health services to a recovery-oriented system of care: Canadian decision maker perspectives. *International Journal of Social Psychiatry*, 56, 168-177.

Piat, M., Sabetti, J., & Couture, A. (2009). What does recovery mean for me? Perspectives of Canadian mental health consumers. *Psychiatric Rehabilitation Journal*, 32, 199-207.

Pollard, L., Gulbard, Y., Levy, G., & Gelkopf, M. (2008). Examining attitudes, beliefs and knowledge of effective practices in psychiatric rehabilitation on a hospital setting. *Psychiatric Rehabilitation Journal*, 32, 124-127.

- Pratt, C. W., Gill, K. J., Barrett, N. M., & Roberts, M. M. (2007). *Psychiatric Rehabilitation, 2nd edition*. Burlington, MA: Elsevier Inc.
- Preskill, H., & Catsambas, T. T. (2006). *Reframing evaluation through appreciative inquiry*. Thousand Oaks, CA : Sage Publications, Inc.
- Priest, H. M., Roberts, P., Dent, H., Blincoe, C., Lawton, D., & Armstrong, C. (2008). Interprofessional education and working in mental health: in search of the evidence base. *Journal of Nursing Management*, 16, 474-485.
- Pringle, A., & Brittle, R. (2008). Care planning across professional and organizational boundaries. In A. Hall, M. Wren, & S. Kirby, *Care planning in mental health: Promoting recovery* (pp. 48-73). Oxford, UK: Blackwell Publishing Ltd.
- Ralph, R. O., Kidder, K., & Phillips, D. (2000). *Can we measure recovery? A compendium of recovery and recovery-related instruments*. Cambridge, MA: Human Services Research Institute.
- Repper, J. (2000). Adjusting the focus of mental health nursing: Incorporating services users' experiences of recovery. *Journal of Mental Health*, 9, 575-587.
- Rickwood, D. (2004, January). *Recovery in Australia: Slowly but surely*. Retrieved February 2, 2008, from Australian e-Journal for the Advancement of Mental Health: <http://www.auseinet.com/journal/vol3iss1/rickwoodeditorial.pdf>
- Ridgway, P. (2001). Restoring psychiatric disability: Learning from first person recovery narratives. *Psychiatric Rehabilitation Journal*, 24, 335-343.
- Robert, G., Hardacre, J., Locock, L., Bate, P., & Glasby, J. (2003). Redesigning mental health services: Lessons on user involvement from mental health collaborative. *Health Expectations*, 6, 60-71.
- Roe, R. A. (2002). What makes a competent psychologist? *European Psychologist*, 7, 192-202.
- Rolls, L., Davis, E., & Coupland, K. (2002). Improving serious mental illness through interprofessional education. *Journal of Psychiatric and Mental Health Nursing*, 9, 317-324.
- Rubin, R., Kerrel, R., & Roberts, G. (2011). Appreciative inquiry in occupational therapy education. *British Journal of Occupational Therapy*, 74, 233-240.
- Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, 20, 529-539.
- Rüsch, N., Lieb, K., Bohus, M., & Corrigan, P. W. (2006). Self-stigma, empowerment, and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services*, 57, 399-402.

- Salgado, J. D., Deane, F. P., Crowe, T. P., & Oades, L. G. (2010). Hope and improvements in mental health service providers' recovery attitudes following training. *Journal of Mental Health*, 19, 243-248.
- Salyer, M. P., Tsai, J., & Stultz, T. A. (2007). Measuring recovery orientation in a hospital setting. *Psychiatric Rehabilitation Journal*, 31, 131-137.
- Schinkel, M., & Dorre, M. (2006). *Toward recovery competencies in Scotland: The views of key stakeholder groups*. Retrieved Oct. 28, 2008, from Scottish Recovery Network: <http://www.scottishrecovery.net/View-document-details/139-Towards-Recovery-Competencies-in-Scotland—Full-Report.html>
- Scott, A., & Wilson, L. (2011). Valued identities and deficit identities: Wellness Recovery Action Planning and self-management in mental health. *Nursing Inquiry*, 18, 40-49.
- Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality*. London, UK: Sainsbury Centre for Mental Health.
- Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. New York, NY: Cambridge University Press.
- Slade, M. (2009). Recovery-focussed mental health services: The Personal Recovery Framework. In M. Slade, *Personal recovery and mental illness: A guide for mental health professionals* (pp. 77-93). Cambridge, UK: Cambridge University Press.
- Smith, R. C., & Bartholomew, T. (2006). Will hospitals recover?: The implications of a recovery-orientation. *American Journal of Psychiatric Rehabilitation*, 9, 85-100.
- Sowers, W. (2005). Transforming systems of care: The American Association of Community Psychiatrists Guidelines for recovery oriented services. *Community Mental Health Journal*, 41, 757-774.
- Spaniol, L., Koehler, M., & Hutchinson, D. (1994). *The Recovery Workbook: Practical Coping and Empowerment Strategies for People with Psychiatric Disability*. Boston, MA: Center for Psychiatric Rehabilitation, Trustees of Boston University.
- Spaniol, L., Wewiorski, N. J., Gangne, C., & Anthony, W. A. (2002). The process of recovery from schizophrenia. *International Review of Psychiatry*, 14, 327-336.
- Spencer, L. M., & Spencer, S. M. (1993). *Competence at work: Models for superior performance*. New York, NY: John Wiley & Sons, Inc.
- Stevenson, C., Barker, P., & Fletcher, E. (2002). Judgement days: developing an evaluation for an innovative nursing model. *Journal of Psychiatric and Mental Health Nursing*, 9, 271-276.

- Substance Abuse and Mental Health Services Administration (SAMHSA). (2006). *National consensus statement on mental health recovery*. Retrieved February 2, 2008, from Substance Abuse and Mental Health Services Administration (SAMHSA): <http://www.samhsa.gov>
- Tay, S. C., Pariyasami, S., Ravindran, K., Ali, M. I., & Rowsudeen, M. T. (2004). Nurses' attitudes toward people with mental illnesses in a psychiatric hospital in Singapore. *Journal of Psychosocial Nursing*, 42, 41-47.
- Tendora, & Davidson. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. Retrieved February 22, 2010, from Connecticut Department of Mental Health and Addiction Services: <http://www.ct.gov/dmhas/lib/dmhas/publications/practiceguidelines.pdf>
- Tetroe, J. (2007). *Knowledge translation at the Canadian Institutes of Health Research: A primer*. Retrieved December 7, 2011, from National Center for the Dissemination of Disability Research: <http://www.ncddr.org/kt/products/focus/focus18/>
- The Standing Senate Committee On Social Affairs Science and Technology. (2006). *Out of the shadows at last*. Retrieved 10 31, 2011, from Parliament of Canada: <http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/pdf/rep02may06high-e.pdf>
- Thomas, S. P., Shattell, M., & Martin, T. (2002). What's therapeutic about the therapeutic milieu? *Archives of Psychiatric Nursing*, 3, 99-107.
- Tondora, J., Delphin, M., Andres-Hyman, R., O'Connell, M. J., & Davidson, L. (2008, December). *Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions (Second edition)*. Retrieved April 4, 2011, from Department of Mental Health and Addiction Services, State of Connecticut: <http://www.ct.gov/dmhas/lib/dmhas/recovery/practiceguidelines2.pdf>
- Torgalsbøen, A.-K. (2005). What is recovery from schizophrenia? In L. Davidson, C. Harding, & L. Spaniol, *Recovery from severe mental illness: Research evidence and implications for practice, Volume 1* (pp. 302-315). Boston, MA: The Center for Psychiatric Rehabilitation.
- Townsend, E., & Morgan, C. (1998). *Good intentions overruled: A critique of empowerment in the routine organization of mental health services*. Toronto, ON: University of Toronto Press.
- Tsai, J., Salyers, M. P., & McGuire, A. B. (2011). A cross-sectional study of recovery training and staff attitudes in four community mental health centers. *Psychiatric Rehabilitation Journal*, 3, 186-193.
- ÜÇÖK, A. (2007). Other People Stigmatize... But, What About us? Attitudes of Mental Health Professionals Towards Patients with Schizophrenia. *Archives of Neuropsychiatry*, 44, 108-116.

- Uppal, S., Oades, L. G., Crowe, T. P., & Deane, F. P. (2010). Barriers to transfer of collaborative recovery training into Australian mental health services: implications for the development of evidence-based services. *Journal of Evaluation in Clinical Practice*, 16, 451-455.
- Varley, J. (2007). Frustrated and angry. In M. Hardcastle, D. Kennard, S. Grandison, & L. Fagin, *Experiences of mental health in-patient care* (pp. 95-98). Hove, East Sussex: Routledge.
- Vauth, R., Kleim, B., Wirtz, M., & Corrigan, P. W. (2007). Self-efficacy and empowerment as outcomes of self-stigmatizing and coping in schizophrenia. *Psychiatric Research*, 150, 71-80.
- Wallace, T., Robertson, E., Millar, C., & Frisch, S. R. (1999). Perceptions of care and services by the clients and families: A personal experience. *Journal of Advanced Nursing*, 29, 1144-1153.
- Whitehead, C. (2007). The doctor dilemma in interprofessional education and care: how and why will physicians collaborate? *Medical Education*, 41, 1010-1016.
- Whitley, R., Gingerich, S., Lutz, W. J., & Mueser, K. T. (2009). Implementing the illness management and recovery program in community mental health settings: Facilitators and Barriers. *Psychiatric Services*, 60, 202-209.
- Wilson, S. (1996). Consumer empowerment in the mental health field. *Canadian Journal of Community Mental Health*, 15, 69-85.
- Yale Program for Recovery and Community Health. (2011). *Consultation and training for systems transformation*. Retrieved May 6, 2011, from Yale Program for Recovery and Community Health:  
<http://www.yale.edu/prch/offer/documents/PRCHConsultationandTrainingFrameworkpubl4pageDRAFT.pdf>
- Young, A. S., Chinman, M., Forquer, S. L., Knight, E. L., Vogel, H., Miller, A., et al. (2005). Use of a consumer-led intervention to improve provider competencies. *Psychiatric Services*, 56, 967-975.
- Young, A. S., Forquer, S. L., Tran, A., Starzynski, M., & Shatkin, J. (2000). Identifying clinical competencies that support rehabilitation and empowerment in individuals with severe mental illness. *The Journal of Behavioral Health Services & Research*, 27, 321-333.

## Appendix A

# Queen's University Health Science & Affiliated Teaching Hospitals Research Ethics Board Approval

QUEEN'S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING  
HOSPITALS RESEARCH ETHICS BOARD



September 12, 2008

This Ethics Application was subject to:

- Full Board Review  
Meeting Date:  
 Expedited Review

Ms. Shu-Ping Chen  
School of Rehabilitation Therapy  
Louise D. Acton Building  
Queen's University

Dear Ms. Chen,


**Study Title:** The development of recovery competencies for mental health providers  
working with people with serious mental illness  
**Co-Investigators:** Dr. T. Krupa

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol and consent forms for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair's signature below. This approval will be reported to the Research Ethics Board. Please attend carefully to the following list of ethics requirements you must fulfill over the course of your study:

- **Reporting of Amendments:** If there are any changes to your study (e.g. consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval. (see <http://www.queensu.ca/vpr/reb.htm>).
- **Reporting of Serious Adverse Events:** Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.
- **Reporting of Complaints:** Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. **Note:** All documents supplied to participants must have the contact information for the Research Ethics Board.
- **Annual Renewal:** Prior to the expiration of your approval (which is one year from the date of the Chair's signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

  
\_\_\_\_\_  
Chair, Research Ethics Board

  
\_\_\_\_\_  
Date

ORIGINAL TO INVESTIGATOR - COPY TO DEPARTMENT HEAD - COPY TO HOSPITAL(S) /P&T (If appropriate) - FILE COPY

Study Code: REH-442-08

- Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete

## Appendix B

# Ethics Approval from Research Review Committee, Providence Continuing Care Centre, Kingston



many paths  
one mission

February 10, 2009

### St. Mary's of the Lake

#### Hospital site

Complex Continuing Care  
Geriatric Medicine  
Rehabilitation  
Palliative Care

340 Union Street  
Kingston, Ontario  
K7L 5A2  
Tel 613-544-5220  
Fax 613-544-8558

### Mental Health Services site

Adult Treatment & Rehabilitation  
Geriatric Psychiatry  
Forensic Psychiatry

752 King Street West  
Postal Bag 603  
Kingston, Ontario  
K7L 4X3  
Tel 613-546-1101  
Fax 613-548-5588

### Providence Manor site

Long-Term Care  
275 Sydenham Street  
Kingston, Ontario  
K7K 1G7  
Tel 613-549-4164  
Fax 613-549-7472

www.providencecare.ca

Ms. Shu-Ping Chen  
OTR, PhD. Candidate  
School of Rehabilitation Therapy  
L.D. Acton Building, George Street  
Queen's University

Re: *The Development of Recovery Competencies for Mental Health  
Providers Working with People with Serious Mental Illness*

Dear Ms. Chen

Thank you for your letter of February 3, 2009, responding to the  
recommendations of the Providence Care Research Review Committee  
and for supplying the revised consent forms.

This information was shared with the Research Review Committee  
members.

I am pleased to confirm that with these amendments, the  
committee was comfortable with the project proceeding.

Yours sincerely

John Puxty, M.B., Ch.B., FRCPC  
Chair, Providence Care, Research Review Committee

/gl

c: Ms. Madeline Halladay, Director, Patient Records and Registration  
Dr. Terry Krupa, School of Rehabilitation Therapy, L.D. Acton  
Building, George Street, Queen's University  
Dr. Susan Wood, Director, Office of Research Studies, Queen's  
University

one of the university hospitals of kingston



**Sisters of Providence  
of St. Vincent de Paul**

**Mental Health Services site**

752 King Street West  
Postal Bag 603  
Kingston, Ontario  
K7L 4X3  
613 546-1101  
Fax 613 548-5588

**Providence Manor site  
Long Term Care**

275 Sydenham Street  
Kingston, Ontario  
K7K 1G7  
613 549-4164  
Fax 613 549-7472

**St. Mary's of the Lake  
Hospital site**

Complex Continuing Care  
Geriatric Medicine  
Palliative Care,  
Rehabilitation  
  
340 Union Street  
Kingston, Ontario  
K7L 5A2  
613 544-5220  
Fax 613 544-8558

**St. Vincent de Paul  
Hospital site**

Complex Continuing Care  
Palliative Care  
Rehabilitation  
  
42 Garden Street  
Brockville, Ontario  
K6V 2C3  
613 342-4461  
Fax 613 342-5592

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**AUTHORIZATION AND NOTIFICATION  
OF APPROVED RESEARCH ACTIVITY**

**TITLE OF RESEARCH PROJECT:**

The Development of Recovery Competencies for Mental Health Providers Working with People with Serious Mental Illness

**Provide a brief description of the Research Project, outlining the information required from the Record:**

The purpose of this study is to develop and test an educational program for in-patient mental health providers to increase their competencies in providing recovery-oriented services. There are three phases in this study. Phase One is a provider needs assessment. A recovery competency set will be developed through literature review and key informant interviews. According to the data collected in Phase One, an educational program will be constructed in Phase Two and be validated through focus groups and expert reviews. Finally, in Phase Three, a mixed-method evaluation design will be conducted to examine the effectiveness of this educational program.

**Externally funded?**  Yes  No If yes, provide Source.

[Empty box for source information]

**Principal Investigator:** Shu-Ping Chen

**Name(s) of Co-Investigators:**

Dr. Terry Krupa

**DATA SECURITY Identify methods of maintaining security of the data during and at the end of the study period, such as destruction of raw data.**

1. The principle investigator's laptop is password protected. 2. All data will be stored in a locked file cabinet and maintained for 5 years. Then, the principle investigator will destroy all hard copy data by shredder and delete audio and video recording data.

**Estimated number of records required (Total number):**

**Time period for record review** FROM: (Y/M/D) \_\_\_\_\_ TO: (Y/M/D) \_\_\_\_\_

**AUTHORIZATION**

**DATE:** (Y/M/D) 2009 FEB 13

*[Signature]*  
Signature of PCCC Research Committee Chair or Designate

**DATE:** (Y/M/D) 2009 Feb 23

*[Signature]*  
Signature of Director of Patient Records & Registration Services (PRRS) or Designate



## **Appendix C**

### **Ethics Approval from Centre for Addiction and Mental Health, Toronto**

This ethics approval is for site 1 – Center for Addiction and Mental Health, Toronto - in Phase Three of the study.



## PROTOCOL REFERENCE #026/2011

March 10<sup>th</sup>, 2011

**Jane Paterson**  
Professional Services  
Centre for Addiction and Mental Health  
250 College Street  
Toronto, ON M5S 1A8

Dear Ms. Paterson:

**Re:** Research protocol #026/2011 entitled: "The development of recovery competencies for mental health providers working with people with serious mental illness" by Paterson J, Chen S, et al.

We are writing to advise you that the Centre for Addiction and Mental Health Research Ethics Board (CAMH REB) has granted expedited approval to the above-named research study for a period of one year from the date of this letter<sup>1</sup>. IF THE STUDY IS EXPECTED TO CONTINUE BEYOND THE EXPIRY DATE, YOU ARE RESPONSIBLE FOR ENSURING THE STUDY RECEIVES RE-APPROVAL BY SUBMITTING THE CAMH REB "ANNUAL RENEWAL OF ETHICS APPROVAL" FORM ON OR BEFORE **February 1<sup>st</sup>, 2012**. Should the study be completed prior to the annual renewal date, please submit a final report. The level of continuing review for this study is Level 1.<sup>2</sup>

Your "Information Sheet" and "Informed Consent Form" have been approved and are attached. Subjects should receive a copy of their consent form.

During the course of the research, any significant deviations from the approved protocol (that is, any deviation which would lead to an increase in risk or a decrease in benefit to human subjects) and/or any unanticipated developments within the research should be brought to the attention of the Research Ethics Office.

*Best wishes for the successful completion of your project.*

Yours sincerely,

Susan Pilon, MHSc  
Manager, Research Ethics Office, CAMH

c.c. Chen, Shu-Ping

SP/tl

<sup>1</sup> CAMH Investigators are reminded that should they leave CAMH, they are required to inform the Research Ethics Board of the status of any on-going research. If a study is to be closed or transferred to another facility, the REB must be informed and any advertisements must be discontinued.

<sup>2</sup> Level 1: Review of routine annual reports, changes and amendments to the approved protocol, adverse events, filing of a final report. \*Please retain a printed copy of this letter (and documents if applicable) for your records.

## **Appendix D**

### **Ethics Approval from St. Joseph's Care Group, Thunder Bay**

This ethics approval is for site 2 – Lakehead Psychiatric Hospital of the St. Joseph's Health Care, Thunder Bay, in Phase Three of the study.



St. Joseph's Hospital  
Corporate Office  
30, Box 3251  
St. Algeon St. N.  
Thunder Bay, ON P7B 9G7  
Tel: (807) 545-2431  
Fax: (807) 545-4594

Balmoral Centre  
607 Silcox Dr.  
Thunder Bay, ON P7B 6Z5  
Tel: (807) 523-0515  
Fax: (807) 673-4668

Behavioural Sciences Centre  
390 Little St. N.  
Thunder Bay, ON P7C 9Y7  
Tel: (807) 623-7633  
Fax: (807) 623-7697  
Toll Free: 1-888-495-5862

Diabetes Health Thunder Bay  
245-A Memorial Ave.  
Thunder Bay, ON P7B 6B9  
Tel: (807) 346-2595  
Fax: (807) 346-6936  
Toll Free: 1-888-489-3422

Hogarth Riverview Manor  
290 Little St. N.  
Thunder Bay, ON P7C 4Y7  
Tel: (807) 625-1114  
Fax: (807) 625-4524

Lakehead Psychiatric Hospital  
P.O. Box 2590  
580 Alameda St. N.  
Thunder Bay, ON P7B 5G4  
Tel: (807) 545-4299  
Fax: (807) 545-9372

Sister Margaret Smith Centre  
301 Little Street N.  
Thunder Bay, ON P7C 6A6  
Tel: (807) 684-2100  
Fax: (807) 622-4779

St. Joseph's Health Centre  
710 Victoria Ave. E.  
Thunder Bay, ON P7C 5P7  
Tel: (807) 624-3400  
Fax: (807) 624-3401

St. Joseph's Heritage  
63 Centre St.  
Thunder Bay, ON P7A 4J2  
Tel: (807) 268-4400  
Fax: (807) 268-4320

[www.sjcg.net](http://www.sjcg.net)

March 29, 2011

Ms. Shu-Ping Chen 6sc56@queersu.ca  
School of Rehabilitation Therapy  
Queen's University  
99 University Avenue  
Kingston, Ontario K7L 3N6

Dear Ms. Chen:

Re: Project Number: SJCG REB # 2011003  
Project Title: The development of recovery competencies for in-patient providers working with people with serious mental illness  
Initial Approval: March 20, 2011 - March 29, 2012

Thank you for your submission to the Research Ethics Board for St. Joseph's Care Group. All documentation relating to the above name project was reviewed by the full board on March 7, 2011. The Research Ethics Board of St. Joseph's Care Group grants **research ethics approval** for Protocol # 2011003 "The development of recovery competencies for in-patient providers working with people with serious mental illness". This approval is granted for a period of one year expiring on March 29, 2012.

The quorum for approval was free from conflict and did not involve any member that is associated with this project.

If your project extends past the expiry of this approval, you are required to complete an annual re-approval request prior to the expiry date. When your project is complete, ensure a completion report is provided to Research Services. If you have any questions or concerns, do not hesitate to contact Research Services at St. Joseph's Care Group – LPH.

I remind you of your responsibilities for continuing ethics review as outlined in the signed Research Agreement Form. If, during the course of your research, there are any serious adverse events, changes in the approved protocol or consent form, or any new information that must be considered with respect to the study, these must be submitted to the Research Ethics Office with the appropriate REC form.

St. Joseph's Care Group is interested in your research findings and would be pleased to receive a summary of your final report. We wish you continued success with your future research endeavours.

Sincerely,

Michel Bédard, PhD  
Chair, Research Ethics Board

Care Compassion  
Commitment

## **Appendix E**

### **Ethics Approval from University of Western Ontario, London**

This ethics approval is for site 3 - Regional Mental Health Care London and St. Thomas - in Phase Three of the study.



Use of Human Participants - Ethics Approval Notice

Principal Investigator: Deborah Corring  
 Review Number: 179388  
 Review Level: Delegated  
 Approved Local Adult Participants: 25  
 Approved Local Minor Participants: 0  
 Protocol Title: The Development of Recovery Competencies for Mental Health Providers Working with People with Serious Mental Illness  
 Department & Institution: Psychiatry, St. Joseph's Health Care London  
 Sponsor:  
 Ethics Approval Date: May 02, 2011 Expiry Date: June 30, 2011  
 Documents Reviewed & Approved & Documents Received for Information:

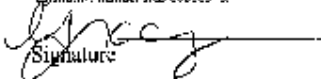
Document Name	Comments	Version Date
UWO Protocol		
Letter of Information & Consent		
Protocol		
Other	Information Sheet	

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (the REB), which is organized and operates according to the Tri-Council Policy Statement: Ethics, Consent of Research Involving Humans and the Health Canada/CTA Good Clinical Practice Protocol: Consolidated Guidelines, and the applicable laws and regulations of Ontario to the review and grants, applies to the above protocol and revision(s) or amendment(s) of the approval date noted above. The membership of the REB also complies with the membership requirements for REBs as set out in Division 3 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the REB's periodic requests for surveillance and monitoring information. If you require an updated approval more please let the REB know by requesting a UWO Clinical Approval Request Form.

Members of the REB who are involved as investigators in research studies, to declare a conflict of interest, or are participating in discussion related to, or outside of, such studies when they are presented to the REB.

The Chair of the REB is Dr. Joseph Gilbert. The UWO REB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000090.

  
 Signature

ethics@uwo.ca

Janis Sutherland jsuthal@uwo.ca	Grace Kelly grace.kelly@uwo.ca
------------------------------------	-----------------------------------

This is an official document. Please retain this original in your files.

The University of Western Ontario  
 Office of Research Ethics  
 Support Services Building Room 3150 • London, Ontario • CANADA • N6A 3K7  
 TEL: 519-661-3036 • F: 519-850-2466 • ethics@uwo.ca • www.uwo.ca/research/ethics

## Appendix F

### Phase One: Information letter and consent form

#### Information Sheet (Phase One)

**Project Title:** The development of recovery competencies for hospital-based mental health providers working with people with serious mental illness

**Investigator:** Shu-Ping Chen, Ph. D. Candidate, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613) 541-1623. E-mail: [6sc56@queensu.ca](mailto:6sc56@queensu.ca).

**Supervisor:** Dr. Terry Krupa, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613)533-6236. E-mail: [terrykrupa@queensu.ca](mailto:terrykrupa@queensu.ca).

#### **Information about this research study**

- What is recovery and recovery-oriented services?  
Recovery involves a process of developing new meaning and purpose in life. The central concept is that one can live a satisfying, hopeful, and productive life no matter what limitations are caused by illness. A recovery-oriented system includes programs and services that adopt these recovery concepts to identify and build upon people's strengths and support them in managing their conditions while regaining meaningful participation in their own lives.
- Why are we doing this?  
Because providers' competencies, including attitude, knowledge, skills, and behaviors, play an essential role in promoting recovery, this study is aimed to develop a recovery educational program for in-patient mental health providers to improve their competencies in delivering recovery-oriented services.
- What is the research study about?  
There are three phases in this study. In Phase One, Shu-Ping Chen is interested in understanding in-patient mental health providers' educational needs and identifying the most salient components of recovery competencies. In order to explore this phenomenon, she is proposing to conduct interviews with consumers, family members, providers, and educators. According to the information gathered in Phase One, she will construct and validate an educational program in Phase Two and examine the effectiveness of this program in Phase Three.
- What will the participants have to do and how long will it take?  
You are invited to participate in an interview with Shu-Ping Chen in Phase One of this study. The interview session will last approximately one hour and will take place at a time and place convenient for you. You will be asked questions about your perspectives on recovery, your opinions on recovery competencies, and the ways to get these competencies.

### **Declaration to Participants**

- You will not be identified in any publication/dissemination of the research findings.
- All information collected during the interviews will only be viewed by Shu-Ping Chen and her supervisor if requested, and remain strictly confidential.
- The study is completely voluntary. If you take part in the study you have the right to: 1) refuse to answer any particular question; 2) withdraw from the study at any time; 3) ask any further questions about the study that occurs to you during your participation; and 4) access to a summary of the findings from the study, when it is concluded. You will be asked to assent and sign an informed consent form before taking part in the study.

If you are interested in participating in this study, please let (the contact person) in Schizophrenia Society/Canadian Mental Health Association/your hospital know. Shu-Ping Chen will contact you directly. She is happy to provide any further information that you may wish. The details about the interview will be explained. If you have any concerns about your rights as a research subject, please contact Dr. Albert Clark, Chair of the Research Ethics Board at (613) 533-6081.

Thank you!



## **Informed Consent Form (Phase One)**

**Title of the project:** The development of recovery competencies for hospital-based mental health providers working with people with serious mental illness.

**Principle Investigator:** Shu-Ping Chen, Ph D. Candidate, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613) 541-1623. E-mail: 6sc56@queensu.ca.

**Supervisor:** Dr. Terry Krupa, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613)533-6236. E-mail: terrykrupa@queensu.ca.

### **Background Information:**

You are being invited to participate in a research study conducted by Shu-Ping Chen as part of her Ph.D. dissertation that focuses on understanding the in-patient mental health providers' recovery competencies and educational needs in psychiatric hospitals. Recovery is a prevalent concept in mental health.

Individuals in recovery can live a meaningful life in a community of their choice while striving to achieve their full potential.

### **Purpose of the study:**

The purpose of this study is to find the most salient components of recovery competencies required for providers working in in-patient units of psychiatric hospitals and the particular challenges these providers may face in acquiring the recovery competencies. The finding of this study will result in a better understanding of providers' educational needs and the ways to improve their recovery competencies. A recovery educational program will be developed using the findings of this study.

### **What is involved?**

You are being asked to participate in an interview with Shu-Ping Chen. This interview will last for about an hour. If you agree, the interview will be audio recorded and transcribed. This interview will take place in a quiet room that is comfortable for you. The beginning of the interview will focus on a brief introduction to the recovery concept. During the interview, you will be asked questions about your perspectives on recovery, your opinions on recovery competencies required for in-patient providers working in psychiatric hospitals, and the ways to get these competencies. You do not have to answer all

the questions. These questions have no right or wrong answer. You just respond to these questions based on your own experiences and thoughts.

**Risks of this study:**

There are no risks associated with the interview.

**Benefits of this study:**

Although you may not benefit directly from this study, some people feel beneficial to share their experiences. This work may lead to an educational program to improve providers' recovery competencies in psychiatric hospitals and may benefit consumers in the future.

**Confidentiality:**

This study has been reviewed and approved by the Queen's University Health Science Research Ethics Board. All information obtained during this study is strictly confidential and your anonymity will be protected at all times. You will be identified only by an identification number, which will be used in reference to data related to you. The consent form and data will be stored separately in locked files and will be available only to Shu-Ping Chen and Dr. Terry Krupa. Documents will be destroyed after 5 years. The information you provide is for research purposes only. You will not be identified in any publication or reports. You will receive a copy of this consent form for your reference.

**Voluntary nature of study/Freedom to withdraw or participate:**

Your participation in this study is voluntary. You may withdraw from this study at any time and your withdrawal will not affect anything in your life.

**People you can contact:**

If you have any question about the interview, your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact the investigator, Shu-Ping Chen, and the study supervisor, Dr. Terry Krupa, at the above address and phone number. Or you can contact Director of the School of Rehabilitation Therapy, Dr. Elsie Culham, at (613)533-6727. If you have any concerns about the ethics of this study you can contact the Chair of the Ethics Review Board, Dr. Albert Clark at (613) 533-6081.



## **Appendix G**

### **Phase One: Interview Protocol**

#### **Introduction and explanation:**

1. Introducing the investigator, explaining the purpose and format of the interview, emphasizing the confidential issues, and getting permission to audio-record.

"Good morning. My name is Shu-Ping Chen". I am a Ph.D. student in Queen's University, School of Rehabilitation Therapy. Today, you are invited to participate in this interview for my research study that focuses on understanding what attitude, knowledge, skills, or behaviours the in-patient mental health providers need to help people recover from mental illness. I will introduce the concept of recovery later. If it is okay with you, may we start on the consent form which will let you know the information about this interview?"

\*Read consent form ..... If you agree to this interview and the audio recording, please sign this consent form.

"So, this interview is to understand your opinions about recovery, the most important components of recovery competencies required for in-patient providers, and the particular challenges these providers may face in practicing recovery competencies."

"Our conversation will take about one hour. If you agree, may I turn on the digital recorder now? Our following conversation will be audio recorded. The purpose of this is that I can get all the details but at the same time be able to carry on an attentive conversation with you. I assure you that all your comments will remain confidential."

2. Introducing: 1) recovery concept; 2) recovery-oriented services; and 3) recovery competencies

\*use handouts

"I'm now going to ask you some questions that I would like you to answer based on your own experiences and thoughts. There are not right or wrong answers. This is just your perspectives. If you do not have an answer or don't want to answer, please say so."

Provider: "I'd like to start by having you briefly describe yourself, your discipline, and your working experience."

Consumer/family: "I'd like to start by having you briefly describe yourself." → your (your family's) age; what's your (your family's) experience in in-patient mental health setting?

### **Part One: Concepts of recovery (Share the idea of recovery)**

1. Have you heard the idea of "recovery"?

→ How do you understand recovery? What does it mean to you?

⇒ What is your definition or criteria of recovery?

⇒ What do people in recovery look like?

⇒ Do you think people can achieve the status of recovery from serious mental illness?

⇒ What factors can help people in recovery?

⇒ What factors can prevent people from being recovery?

⇒ What helps a person needs in the processes of recovery?

→ Can you give me some examples of people who are in recovery and how did you help them?

Consumer/family: How would you (your family) experience recovery? Would you like to share your (his/her) experience of recovery?

### **Part Two: In-patient settings (general ideas about recovery services in in-patient settings)**

"I am interesting in "in-patient setting" because in-patient settings are unique and challenging for facilitating recovery."

1. In your own words, would you describe the in-patient environment and culture in psychiatric hospitals?

2. What are the special challenges facing providers in delivering recovery-oriented services in in-patient settings?
3. Can you give me some examples from your own work in in-patient unit(s), what are good services that you think facilitated recovery practice?  
*Consumer/family: Can you give me some examples when you (your family) were in-patient, what are good services that you think facilitated recovery?*
4. Can you give me some examples from your own work in in-patient unit(s), what services were not going to help recovery?  
*Consumer/family: Can you give me some examples when you (your family) were in-patient, what services were not going to encourage recovery?*
5. From your perspective, how is delivery of recovery-oriented services different in in-patient vs. out-patient settings?
6. It has been argued that providing recovery-oriented services for in-patients is not possible because it's too acute or crisis-oriented. Do you think it is possible? What do you think about this?  
  
→ Some people think it is difficult for in-patient settings to promote recovery because it is a closed setting and so separate from life in the community. What would you say?  
  
→ In-patient settings are usually more biomedical model oriented. What do you think about facilitating recovery in the biomedical-oriented environment?  
*(Explain biomedical model for consumer/family, e.g. illness focused)*
7. Some service users have reported that in-patient experience was traumatic. For example, they feel their dignity was spoilt because they were only allowed to do certain things in a limited space and time. If in-patient hospitalization can be traumatic how does this influence recovery oriented services?

8. Do you have any other ideas about how to facilitate recovery in in-patient units?

**Part Three: The recovery competencies required for in-patient providers (specific in recovery competencies)**

“Any competency thinks about providers needing specific attitude/knowledge/skills/behaviours in their works. Here are some generic recovery competencies that have been developed.” (Show a simple recovery competency set to the interviewee)

“As we know, most recovery knowledge developed is very generic and could be applied anywhere. For example, there is recovery knowledge that applies across in-patient and community services. Here, I would like to explore providers’ recovery competencies required specific in in-patient settings.”

So, except the generic competencies,

1. When think about enabling recovery specific in in-patient setting, what specific attitudes do you think providers should demonstrate?
  - ➔ Any other attitude is important to help people in recovery?
2. When think about encouraging recovery in in-patient setting, what specific knowledge do you think providers should have?
  - ➔ Any other knowledge is important to help people in recovery?
3. What specific skills you think are important and needed for in-patient providers to help people in recovery?
  - ➔ Any other skill is important to help people in recovery?
4. What specific behaviours you think are important and needed for in-patient providers to help people in recovery?

→ Any other behaviour is important to help people in recovery?

5. According to the recovery competencies you mention, what challenge do you think an in-patient provider will face in practicing these competencies?

6. Hypothetically, if you were hiring or training an in-patient provider, what would you look for?

7. (Consumer/family) Do you expect in-patient providers to provide any other services?

8. If you are an in-patient worker now, what educational programs do you need?

9. I'm going to develop a recovery educational program for in-patient providers. What do you think is a priority to include in that training?

**End of the interview**

1. Thank you for your helpful information. Is there anything else I should have asked you?

2. Is there anything you would like to ask me?

I will transcribe the recording. Thank you for your help.



## **Appendix H**

### **Phase Three: Information letter and consent form**

(The information letter and consent form for site 2 are appended as an example)

#### **Information Sheet**

**Project Title:** The development of recovery competencies for mental health providers working with people with serious mental illness

**Investigators:**

Shu-Ping Chen, Ph. D. Candidate, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613) 541-1623. E-mail: [6sc56@queensu.ca](mailto:6sc56@queensu.ca).

Katherine Stewart, OT Reg. (Ont.), Psychosocial Rehabilitation Coordinator, Lakehead Psychiatric Hospital, Thunder Bay, ON, P7B 5G4. Phone number: (807) 343-4336. E-mail: [stewarka@tbh.net](mailto:stewarka@tbh.net)

Terry Krupa, Professor, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613)533-6236. E-mail: [krupat@queensu.ca](mailto:krupat@queensu.ca).

**Information about this research study**

- What is recovery and recovery-oriented services?

Recovery involves a process of developing new meaning and purpose in life. The central concept is that one can live a satisfying, hopeful, and productive life no matter what limitations are caused by illness.

A recovery-oriented system includes programs and services that adopt these recovery concepts to identify and build upon people's strengths and support them in managing their conditions while regaining meaningful participation in their own lives.

- Why are we doing this?

Because providers' competencies, including attitude, knowledge, skills, and behaviors, play an essential role in promoting recovery, this study is aimed to develop and test a recovery educational program for

in-patient mental health providers to improve their competencies in delivering recovery-oriented services.

- What is the research study about?

We have constructed a recovery educational program based on a recovery competency framework developed in previous research. In this study, we are proposing a pilot test to examine the effectiveness of this educational program.

- What will the participants have to do and how long will it take?

We invite you to participate in this recovery educational program. We recruited hospitals providing in-patient services to individuals with mental illness that show clear commitment to recovery. Your hospital has agreed to participate in this study. Direct in-patient service providers in your hospital are invited to participate in this study.

There are two parts to this educational program. Part one is a computer-based self-learning program. Those who agree to participate in this program will need a personal computer at home or at the work place to access the program. Participants can complete this training program in a way that best fits their own schedule (at work or wherever the participants choose). It takes about 5 to 6 hours to complete the program. Participants will have three weeks to complete the program. Before and after the self-learning program, participants will be asked to fill out two questionnaires which will take about 10~15 minutes to complete.

Part two is a group learning program. If you have completed the Part one self-learning program, you will be invited to participate in the group learning program. There will be 3 to 10 participants in a group. Ms. Katherine Stewart will be the group facilitator. The group will meet once a week for six weeks. Each group session lasts for 90 minutes. Participants will be expected to use their own time to participate in the group learning program. At the end of the last group session, you will be asked to fill out the group learning evaluation which may take about 10 minutes to complete in addition to two questionnaires which take about 10-15 minutes to complete.

### **Declaration to Participants**

You will not be identified in any publication/dissemination of the research findings.

- All information collected during the study will only be viewed by the investigators, and remain strictly confidential.
- The study is completely voluntary. If you take part in the study you have the right to: 1) refuse to answer any particular question; 2) withdraw from the study at any time; 3) ask any further questions about the study that occurs to you during your participation; and 4) access a summary of the findings from the study, when it is concluded. Your participation (or non-participation) will in no way affect your employment.

The details about the research processes will be explained in the informed consent form. If you agree to participate in this study, please sign the attached slip and put it into the sealed box in nursing station. We will contact you and set up a time to further discuss the details involved in implementation with you. We would also be happy to provide any further information that you may wish. If you have any concerns regarding your rights as a research participant, or wish to speak to someone other than a research team member about this research project, you are welcome to contact Dr. Albert Clark, Chair of the Research Ethics Board of Queen's University at (613) 533-6081 or Chair, Research Ethics Board, St. Joseph's Care Group, 580 N. Algoma St., Thunder Bay, Ontario P7B 5G4 at (807) 343-4300 ext. 4723 or REB\_Chair@tbh.net.

Thank you!

-----  
*Please tear off and return this slip to the sealed box in nursing station*

Yes, I am interested in this study.

Name: \_\_\_\_\_

Unit: \_\_\_\_\_

Phone number: \_\_\_\_\_

E-mail: \_\_\_\_\_

## **Informed Consent Form**

**Title of the project:** The development of recovery competencies for mental health providers working with people with serious mental illness.

### **Investigators:**

Shu-Ping Chen, Ph. D. Candidate, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613) 541-1623. E-mail: [6sc56@queensu.ca](mailto:6sc56@queensu.ca).

Katherine Stewart, OT Reg. (Ont.), Psychosocial Rehabilitation Coordinator, Lakehead Psychiatric Hospital, Thunder Bay, ON, P7B 5G4. Phone number: (807) 343-4336. E-mail: [stewarka@tbh.net](mailto:stewarka@tbh.net)

Terry Krupa, Professor, School of Rehabilitation Therapy, Queen's University, Kingston, ON, K7L 3N6. Phone number: (613)533-6236. E-mail: [krupat@queensu.ca](mailto:krupat@queensu.ca).

### **Background Information:**

You are being invited to participate in a research study conducted by Shu-Ping Chen as part of her Ph.D. dissertation that focuses on evaluating the effectiveness of a recovery educational program. Recovery is a prevalent concept in mental health. Individuals in recovery can live a meaningful life in a community of their choice while striving to achieve their full potential.

### **Purpose of the study:**

The purpose of this study is to investigate if a recovery educational program can be used as an effective educational package to increase in-patient providers' recovery competencies. This study involves multiple research sites. The finding of this study will result in a better understanding of the ways to improve providers' recovery competencies.

### **Research processes:**

The information will be gathered from in-patient providers of psychiatric hospitals which show clear commitment to recovery. In-patient providers who currently provide care to individuals with serious mental illness between the ages of 18-65 will be invited to participate in this study. There are two parts in the educational program. Part one is a computer-based self-learning program. Before and after the self-

learning program, participants will be asked to complete two questionnaires. It will take about 10~15 minutes to complete the questionnaires.

Part two is a group learning program. If you have completed Part one self-learning program, you will be invited to participate in the group learning program. There will be 3 to 10 participants in a group. The group will meet once a week for six weeks. Each group session lasts for 90 minutes. At the end of the last group session, you will be asked to fill out the group learning evaluation which may take about 10 minutes to complete.

### **Questionnaires:**

When you enter the study, you will be asked to complete two questionnaires: 1) the Recovery Knowledge Inventory which consists of 20 items asking your degree of agreement about recovery concepts; and 2) an investigator developed questionnaire which consists of 20 items asking about your sense of competencies and perceived dilemmas in clinical practice. You may refuse to answer any of these questions if you wish. The investigator will be there to assist you to fill out all these questionnaires. I estimate that it will take about 10~15 minutes of your time to complete the two questionnaires. After completing the self-learning program, you will be asked to fill out the same questionnaires again. If you agree to participate in the group learning program, you will be asked to complete a group learning evaluation at the end of the last group session. The group learning evaluation consists of 18 rating items describing the learning experiences and 4 open-ended questions inviting your comments for further improvement of the educational program. It takes about 10 minutes to complete the learning group evaluation.

### **Intervention:**

You will receive the consent form, the pre-tests, and the educational materials in an introductory meeting. Please sign the consent form, complete the pre-tests, and return them back to the investigator. The self-learning materials for Part One of this educational package include a CD-ROM and a guiding booklet navigating you through the learning process. You need personal computer at home or at the work place to access the program. You can use this training program in a way that meets your own schedule/needs. It takes about 5 to 6 hours to complete the program. You will have three weeks to complete the program. After completing the self-learning program, if you agree to participate in the group learning program, the group facilitator, Katherine Stewart, will contact you to set up the time and place for group sessions. You are expected to use your own time to participate in the group learning program. You will receive detail

information regarding the group settings. The 90-minute group sessions will be held once a week for 6 weeks.

**Risks of this study:**

There are no risks associated with the educational program or the measurements.

**Benefits of this study:**

Although you may not benefit directly from this study, you will be contributing to the development of an educational program useful in meeting training needs of in-patient mental health providers. Participants who complete the program will be provided a certificate of completion that might be used towards meeting the continuous improvement requirements of professional organizations.

**Confidentiality:**

This study has been reviewed and approved by the Queen's University Health Science Research Ethics Board and the Research Ethics Board of SJCG. SJCG manager may know you have participated, but the content of evaluations and learning sessions will be kept confidential. You will be identified only by an identification number, which will be used in reference to data related to you. The consent form and hard copy data will be stored separately in locked files and will be available only to the investigators. Shu-Ping Chen's laptop is password protected. Only Shu-Ping can access the electronic records and data in her computer. However, because this is a Ph.D. study, the thesis committee may have access to all de-identified data upon request. All data will be maintained for 5 years from the commencement of the study. Then, Shu-Ping will delete the electronic data from the laptop and destroy all hard copy data by shredder. The information you provide is for research purpose only. You will not be identified in any publication or reports. You will receive a copy of this consent form for your reference.

**Voluntary nature of study/Freedom to withdraw or participate:**

Your participation in this study is voluntary. You may withdraw from this study at any time and your withdrawal will carry no adverse consequence of any sort – your employment relationship, position, or service providing in the mental health field will not be influenced.

**People you can contact:**

If you have any question about the questionnaires and intervention or are dissatisfied at any time with any aspect of this study, you may contact the investigators at the above address and phone number. Or you can contact Director of the School of Rehabilitation Therapy Queen's University, Dr. Elsie Culham, at (613)533-6727. If you have any concerns regarding your rights as a research participant, or wish to speak to someone other than a research team member about this research project, you are welcome to contact Dr. Albert Clark, Chair of the Research Ethics Board of Queen's University at (613) 533-6081 or Chair, Research Ethics Board, St. Joseph's Care Group, 580 N. Algoma St., Thunder Bay, Ontario P7B 5G4 at (807) 343-4300 ext. 4723 or [REB\\_Chair@tbh.net](mailto:REB_Chair@tbh.net).





## Appendix I

### Phase Three: Pre- and post-test instruments

Date: \_\_\_\_\_

Code: 2-

Y	Y	D	D
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*Please enter your year of birth (last two digits) and date of birth as your code*

#### PART ONE: DEMOGRAPHIC DATA

1. Are you female or male?     Female     Male

2. How old are you?

18-24     25-29     30-39     40-49     50-59     60 or up

3. What is your job title? (Check all that apply)

Case manager     Service coordinator     Administrator

Psychiatric nurse     Occupational therapist     Social worker

Psychologist     Psychiatrist     Rehabilitation counsellor

Other: \_\_\_\_\_

4. How many years you have worked in mental health? \_\_\_\_\_

5. How many years you have worked in the current in-patient unit? \_\_\_\_\_

6. What is the highest level of education you have completed?

High school     College     Bachelor     Master

PhD     MD     Other: \_\_\_\_\_

7. Have you completed any recovery-related training?     Yes     No

If yes, please specify the training programs including the name and duration of the programs:

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## PART TWO: RECOVERY KNOWLEDGE INVENTORY

*Developed by the Yale Program for Recovery and Community Health, New Haven, CT (Bedregal, O'Connell, & Davidson, 2006)*

*What is your understanding of the recovery process? Please rate the following items using the scale*

*below:*    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 too high of expectations 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 |

### PART THREE: RECOVERY KNOWLEDGE APPLICATION INVENTORY

*The following items evaluate your own sense of specific competencies you possess to apply recovery knowledge in your current practice in the in-patient context. Based on your understanding of the recovery process and **your current practice context**, please rate the following items:*

	1	2	3	4	5
	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. The recovery-oriented services are applicable in the in-patient context.	1	2	3	4	5
2. When patients have suggestions for improving our services, I am often able to respect their voices and try to implement their suggestions.	1	2	3	4	5
3. I feel able to listen to and follow the choices and preferences of patients.	1	2	3	4	5
4. I am able to engage patients in activities that are meaningful to them.	1	2	3	4	5
5. I am able to engage patients in making decisions.	1	2	3	4	5
6. I am able to talk about my patients' strengths in the team meeting.	1	2	3	4	5
7. I feel able to share my knowledge of recovery with my colleagues.	1	2	3	4	5
8. I am able to explore resources for my patients.	1	2	3	4	5
9. I am able to help patients instill hope and build confidence.	1	2	3	4	5
10. I am able to support my patients' setbacks after they take a risk.	1	2	3	4	5
11. I am able to contact the community resources or programs where my patients might need when they discharge.	1	2	3	4	5
12. I am able to promote self-advocacy for patients.	1	2	3	4	5

## PART FOUR: RATING CLINICAL DILEMMAS

*Literature related to delivery of recovery-oriented services in in-patient context suggests that in-patient providers are faced with a range of dilemmas. Dilemmas are difficult situations that require a choice between options that are or seem equally unfavorable or mutually exclusive. Think about your practice. Please rate the following dilemmas which you might perceive in your practice in terms of frequency and your sense of being able to negotiate these dilemmas.*

	Dilemmas	Please circle one in each column					
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
1	Lack of agreement between patients' needs/choices and the structure of the unit (for example, it is difficult to address different patients' needs in a restricted environment)	Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
2	Challenges related to ensuring human rights when delivering some interventions, for example, those interventions for maintaining a safe environment	Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
3	Challenges in delivering services that are strength-based in a context that is largely problem-based	Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
4	The in-patient context places time restrictions on services that compromise the delivery of recovery-oriented services	Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
5	Challenges related to sharing power with patients (For example, sharing power may interfere with professional boundary; patients may not be capable to make a decision)	Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
6	In-patient experience of acute illness or distress prevents them from engaging in activities associated with recovery	Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
7	Challenges related to lack of colleague or system support for delivering recovery-oriented services	Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always

8	Dilemmas that exist when it is believed that patients' decisions may lead to harmful or negative outcomes	Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
		Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
9	Dilemmas that exist when patients are in a negative cycle of hopelessness or repeated relapse	Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
		Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
10	Dilemmas that exist when stigmas prevent patients from moving forward	Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
		Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent

What other dilemmas you have experienced when you intend to deliver a recovery-oriented service?

11		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
		Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
12		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
		Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent
13		Frequency	1 Never	2 Rarely	3 Sometimes	4 Very often	5 Always
		Sense of competency	1 Not at all	2 Very little	3 Somewhat	4 To a considerable degree	5 To a great extent

*Please return the evaluation to the research coordinator.*

*Thank you for your participation!*

(For those who participate in the group learning modules)

## PART FIVE: GROUP LEARNING PROGRAM EVALUATION

*In order to understand the effectiveness of the learning modules in meeting your needs, I need your input. Please rate the following items and make any comments that will help me improve the learning modules.*

1	2	3	4	5
Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
1. I enjoyed this group learning experience.				1 2 3 4 5
2. This program was worthwhile in terms of my time away from normal job duties.				1 2 3 4 5
3. The topics and exercises covered in the learning program were relevant to my job.				1 2 3 4 5
4. The handouts will be of help to me.				1 2 3 4 5
5. The group schedule was suitable.				1 2 3 4 5
6. The facilities and materials were suitable.				1 2 3 4 5
7. The group learning method was suitable.				1 2 3 4 5
8. I will recommend this program to my colleagues.				1 2 3 4 5
9. There were noticeable and measurable changes in the way I practice during the past six weeks.				1 2 3 4 5
10. I feel like the learning experience will help me do my job better.				1 2 3 4 5
11. The learning experience was helpful for my personal development.				1 2 3 4 5
12. I will be able to apply much of the learning experience to my job.				1 2 3 4 5
13. The group learning experience enabled helpful change to the way I think and behave afterward.				1 2 3 4 5
14. I feel that I am able to transfer the learning to other clinical situations.				1 2 3 4 5
15. I feel that I am well prepared to provide recovery-oriented services in my current practice.				1 2 3 4 5

16. I am eager to provide recovery-oriented services in my unit after leaving the educational program. 1 2 3 4 5

17. Changes resulting from the group learning experience will promote recovery-oriented practices for me and my team. 1 2 3 4 5

18. Overall, I am satisfied with this educational program. 1 2 3 4 5

19. What two (2) things did you find most helpful about this learning program.

20. If you are not doing some of the things that you were encouraged to do in the group, why not? Please list two possible reasons.

21. What suggestions do you have for making the program more helpful?

*Please return the evaluation to the group facilitator. Thank you for your participation!*

## Appendix J

### The results of Rating Clinical Dilemmas

	Dilemmas	All (N=23)	Pre-test	Post-test 1
1	Lack of agreement between patients' needs/choices and the structure of the unit (for example, it is difficult to address different patients' needs in a restricted environment)	Frequency	3.53	3.17
			$p = .248$	
		Sense of competency	3.27	3.37
			$p = .260$	
2	Challenges related to ensuring human rights when delivering some interventions, for example, those interventions for maintaining a safe environment	Frequency	2.65	2.79
			$p = .782$	
		Sense of competency	3.24	3.71
			$p = .073$	
3	Challenges in delivering services that are strength-based in a context that is largely problem-based	Frequency	3.28	3.13
			$p = .317$	
		Sense of competency	3.45	3.59
			$p = .564$	
4	The in-patient context places time restrictions on services that compromise the delivery of recovery-oriented services	Frequency	3.40	3.21
			$p = .371$	
		Sense of competency	3.50	3.43
			$p = .805$	
5	Challenges related to sharing power with patients (For example, sharing power may interfere with professional boundary; patients may not be capable to make a decision)	Frequency	3.11	2.92
			$p = .248$	
		Sense of competency	3.23	3.50
			$p = .218$	
6	In-patient experience of acute illness or distress prevents them from engaging in activities associated with recovery	Frequency	3.56	3.33
			$p = .058$	
		Sense of competency	3.32	3.22
			$p = .808$	
7	Challenges related to lack of colleague or system support for delivering recovery-oriented services	Frequency	3.06	3.04
			$p = .564$	
		Sense of competency	3.41	3.30
			$p = .794$	
8	Dilemmas that exist when it is believed that patients' decisions may lead to harmful or negative outcomes	Frequency	3.39	3.04
			$p = .059$	
		Sense of competency	3.18	3.22
			$p = .976$	
9	Dilemmas that exist when patients are in a negative cycle of hopelessness or repeated relapse	Frequency	3.79	3.25
			$p = .012^*$	
		Sense of competency	3.57	3.30
			$p = .100$	
10	Dilemmas that exist when stigmas prevent patients from moving forward	Frequency	3.00	2.92
			$p = .641$	
		Sense of competency	3.33	3.43
			$p = 1.00$	