Evaluation of Recovery in Practice Training

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Table of Contents

Notes and acknowledgements **iii**

1. Introduction **1**

About SRN and recovery 1
Recovery training and its policy context 2
Piloting Recovery in Practice 4

2. Evaluation methods **7**

Evaluation framework and overview of methods 7
Pre-training questionnaire 8
Administration of pre-training questionnaire 9
Post training questionnaire 9
Administration of post training questionnaire 10
Interviews 10

3. Findings **12**

What do we know about the training participants? 12
What do we know about interviewees? 17
What did participants think of the training? 19
Was the training effective? 26
What had interviewees done as a result of attending the training? 37
Trainers' views 41

4. Reflections and recommendations **44**

Adding value rather than preaching to the converted 44
Diverse needs and targeting issues 45
Meeting the needs of front-line workers 46
Supporting and mainstreaming recovery in organisations 48
The belief inventory 50
Concluding comments 51

5. Appendices **52**

Notes and acknowledgements

Terminology

Throughout this report, the term **service users** will be used to refer to people who have (or are believed to have) long-term or enduring mental health problems. However, it is acknowledged that not all these people will actually use, or even be known to mental health services. In fact, some may not have even been formally diagnosed as having a mental health problem. Nevertheless service user is the chosen term in this report as these individuals are receiving support from the voluntary sector providers who have participated in this evaluation.

When presenting an individual's view, this report refers to the contributor as s/he. This convention is used to further protect the anonymity of those involved in the evaluation.

Disclaimer

The opinions expressed in this publication are those of the author and are not necessarily those of the Scottish Recovery Network.

Acknowledgements

We would like to acknowledge all evaluation participants who generously shared their views.

1 Introduction

Summary of key points:

The Scottish Recovery Network (SRN) commissioned an evaluation of a two day pilot training programme on recovery for people working in voluntary sector organisations.

This is the report of that evaluation.

1.1 The Scottish Recovery Network (SRN) commissioned Health in Mind to develop and deliver a new two day training programme on recovery in partnership with Penumbra[1].

1.2 The new training programme was targeted at individuals working in voluntary organisations, specifically organisations that had a role in supporting people with mental health problems.

1.3 The training programme was planned to be highly experiential in nature. As such it was intended that the training would enable participants to reflect on and consider their personal and professional values and practices.

1.4 Through a process of participant reflection, the training programme's anticipated outcomes were:

- to engender recovery values, in particular, that recovery is possible; and
- develop participants' knowledge and skills in ways that maximise service users' involvement.

1.5 SRN commissioned Jacki Gordon + Associates to evaluate this training. This is the report of that evaluation.

About SRN and recovery

"Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process." [2]

1.6 SRN was launched in December 2004 as an initiative under the National Programme for Mental Health and Wellbeing. Its main purpose is to promote recovery at a national and local level and to support recovery practices.

[1] Both Health in Mind and Penumbra are voluntary organisations that support people with mental health problems and promote recovery.

[2] http://www.scottishrecovery.net/What-is-Recovery/what-is-recovery.html

1.7 Definitions vary of recovery can vary. However, the notion of recovery is underpinned by some *key beliefs* and *values*. These include:

- recovery is possible for anyone with a mental health problem;
- an appreciation that recovery is an individual process and that individuals are experts on their own lives; and
- recovery is a journey, and this journey can involve set backs.

1.8 Recovery practices are those that embrace and embody such values. As such, recovery practices require that service providers:

- operate from a position of optimism and engender a sense of hope in their clients;
- view people with mental health problems as individuals, taking them and their experiences seriously;
- are empowering; and
- appreciate that there will be circumstances where a level of risk is inevitable and acceptable.

1.9 Recovery therefore requires that those who support people with mental health problems (notably those working both in the statutory and non-statutory services) encourage and support their clients to become active partners in their own care. To achieve this, it has been suggested that practitioners need to think about how stigma and power dynamics influence their practice, and engage in a respectful and reciprocal (two-way) relationship with service users[3].

Recovery training and its policy context

1.10 In December 2006, Delivering for Mental Health[4] (the mental health delivery plan for Scotland) set outs its vision, targets and commitments for mental health services in Scotland. This plan not only highlighted the importance of recovery as a guiding principle for mental health services, but established recovery practices as a means to benchmark whether services are being structured and delivered in accordance with the expectations of the Scottish Government.

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[3] Berzins K (2006) *Implementing a recovery approach in policy and practice: A review of the literature.* Scotland's National Programme for Improving Mental Health and Wellbeing: Small Research Projects Initiative 2005-06. University of Glasgow. Available at: www.scotland.gov.uk/Publications/2006/06/19103019/1.

[4] Scottish Executive (2006) *Delivering for Mental Health*. Scottish Executive, Edinburgh.

1.11 In the same year, Rights, Relationships and Recovery, the report of the National Review of Mental Health Nursing in Scotland was published[5]. This review placed a strong emphasis on promoting and supporting recovery focused practices and services. Since then there have been a number of notable developments to support the development of recovery values and practices in Scotland.

1.12 In September 2007, NHS Education for Scotland (NES) and SRN produced and published Realising Recovery: a National Framework for Learning and Training in Recovery Focused Practice. While this framework was developed to fulfil one of the actions in Rights, Relationships and Recovery and was therefore written primarily for nurses, the authors assert that the framework is equally applicable to others who work in mental health.

1.13 The 10 Essential Shared Capabilities for Mental Health (10 ESCs) is one of the building blocks for addressing many of the elements in the framework. The 10 ESCs are: working in partnership; respecting diversity: practising ethically; challenging inequality; promoting recovery; identifying people's needs and strengths; providing service user centred care; making a difference; promoting safety and positive risk taking; and personal development and learning.

1.14 These 10 ESCs were originally developed in England. Using these as the basis, NES worked with an expert group (involving service users, carers and statutory and voluntary organisations, including SRN) to produce a training pack and learning materials that would be relevant to the Scottish context. These were primarily developed to meet one of the requirements in Rights, Relationships and Recovery. However, they are intended to be relevant to anyone involved in mental health work irrespective of their role or the setting in which they work.

1.15 NES has supported the rollout of the 10 ESC training to NHS Scotland Boards by commissioning a training for trainers' programme. Health in Mind and Penumbra were commissioned to deliver this (in partnership). The impact of this has been assessed by researchers at Robert Gordon University[6].

1.16 A complementary set of learning materials – Realising Recovery - have been developed by SRN and NES. These materials are informed by lived experiences of people in recovery, in particular, as collected through SRN's Narrative Research project.

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[5] Scottish Executive (2006) *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland.* Scottish Executive, Edinburgh.

[6] Macduff, C et al (2010) An Evaluation of the Impact of the Dissemination of Educational Resources to Support Values-Based and Recovery-Focused Mental Health Practice. Available at: http://www.nes.scot.nhs.uk/documents/publications/classa/Executive_Summary_Mar_10.pdf

1.17 The Realising Recovery materials are intended to provide additional insights to help mental health workers 'work alongside' service users in planning and making their unique recovery journeys. Realising Recovery has six modules: 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.

Piloting *Recovery in Practice*

1.18 In an attempt to make the learning materials described above available to workers in the voluntary sector, SRN commissioned the pilot of a two day training programme called Recovery in Practice. This two day course is based on the 10 ESCs and Realising Recovery resources and is intended to be an introduction to recovery focused and values based mental health practice. Thus its anticipated learning outcomes were described as including:

- greater understanding of recovery values and recovery focused practice; and
- increased ability to reflect on and develop personal practice.

1.19 SRN promoted the training as suitable for 'people providing mental health services who are based in the voluntary sector', disseminating information on this new training via its website and associated e-bulletin. This e-bulletin is sent to approximately 6000 network members, many of whom are known to work in the voluntary sector.

1.20 In order to make the training available to a range of organisations, SRN requested that applications for places should be lodged by the nominating organisations (rather than by individuals). SRN suggested that 'nominees could include:

- paid or voluntary staff involved in providing direct support to people;
- people who have a training or dissemination role within your organisation, who may be well placed to share their learning;
- more experienced practitioners with a supervisory role'.

Organisations were invited to nominate up to eight workers.

1.21 Four training sessions were offered with each lasting two (consecutive) days. Training was scheduled to run between October 2009 and February 2010 in different locations across Scotland[7].

[7] The original intention had been to run these in Aberdeen, Dundee, Edinburgh and Glasgow. However, due to the nature of the interest/ demand, the course that had initially been intended to run in Dundee ran in Glasgow instead.

1.22 The training was intended to be highly experiential – a feature that was considered to be important in the production of the learning materials for both the 10 ESCs and Realising Recovery. To support this experiential quality, Recovery in Practice places were restricted: a total of twenty places were available at each training session.

1.23 A workbook was produced to accompany the training. This was intended to provide a number of functions such as: detailing the experiential exercises in which the participants would engage; setting these exercises within a context (specifically, linking these to the relevant 10 ESCs and Realising Recovery modules); and providing opportunities for participants to note down their own thoughts and reflections. It was also intended to be used as an aide memoire after the training.

1.24 The training programme was delivered by Health in Mind and Penumbra i.e. the same partnership as that responsible for delivering the 10 ESCs training.

1.25 Previous research has highlighted the value of training participants hearing about recovery 'straight from the horse's mouth'[8,9] Furthermore service user input in the delivery of training courses has been highlighted as an important driver of change[10]. Consistent with these markers of good practice, individuals with lived experience of mental health problems and recovery were heavily involved in the delivery of the Recovery in Practice training: they jointly facilitated the training and also shared personal accounts of their recovery to explain key recovery principles.

1.26 More specifically, the content of the training included the establishment of ground rules (a 'working agreement') and a brief description of the 10 ESCs and Realising Recovery materials, and then consideration/exploration of:

- what recovery is, what helps and hinders recovery;
- the importance of identity (and how this can be shaped by the experience of living with mental health problems);
- relationships and boundaries between workers and the development of interpersonal expertise;
- equality, diversity and discrimination and developing inclusive practice;
- strengths-based approaches to supporting others/recovery based planning; and

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[8] AskClyde (2007) A Literature Review and Documentary Analysis on Recovery Training in Mental Health Practice. Edinburgh NHS Education for Scotland

[9] Macduff, C et al (2010) An Evaluation of the Impact of the Dissemination of Educational Resources to Support Values-Based and Recovery-Focused Mental Health Practice. Available at: http://www.nes.scot.nhs.uk/documents/publications/classa/Executive_Summary_Mar_10.pdf

[10] Schinkel M and Dorrer N (2007) Towards Recovery Competencies in Scotland: The Views of Key Stakeholder Groups. Edinburgh: Scottish Executive. Available from www.scottishrecovery.net

- person centred planning and tools.

1.27 As this was a new training programme, SRN commissioned an independent evaluation to address three key questions:

- What do participants think of the training?
- Is the training effective?
- Could the training be improved, and if so how?

2 Evaluation methods

2.1 This section briefly describes the framework used for structuring the evaluation and the methods used.

Summary of key points:

This evaluation explores participants' reactions to the training, whether they learned anything new, and for a small sample - whether they did things differently after the training

It addresses these questions through analysis of:

- *questionnaires administered before the training and again at the end of the training; and*
- *interviews conducted with six individuals before the training and two - three months after.*

The evaluation also explored views on how the training could be improved.

To obtain a rounded view, the trainers were interviewed too.

Evaluation framework and overview of methods used

2.2 The Kirkpatrick model[11] is a well established framework that is frequently used to guide evaluations of training. This model assesses training at four levels as described below.

1. **Reaction:** What do participants feel about the training? This includes not only views of the training content, but also training processes.
2. **Learning:** Do participants find out anything new? If so, what insights/knowledge did they gain?
3. **Behaviour / performance:** What changes take place in what participants actually *do* as a result of attending the training? i.e. are participants applying what they learned, and if so are they doing so in the ways anticipated?
4. **Results:** What is the impact of participants' changed behaviour over the longer term?

The current evaluation addresses Kirkpatrick levels one, two and three.

2.3 The Kirkpatrick framework does not take account of what participants bring to the training e.g. before attending the training, what did participants already

[11] Kirkpatrick DL (1959) Techniques for evaluating training programmes, *Journal of American Society of Training Directors, 13*, pp. 3-9 and 21-26; *14,* pp. 13-18 and 28-32.

know? This evaluation broadens its focus beyond Kirkpatrick levels one, two and three to address such considerations.

2.4 Accordingly, the evaluation of *Recovery in Practice* comprised the following elements:

- questionnaires administered to all participants before attending the training and at the end of the training;
- one-to-one interviews with a sample of participants before the training and then again two - three months after the training; and
- one-to-one interviews with the trainers.

2.5 These mixed methods were intended to provide *breadth* (through administering questionnaires to all participants), *depth* through one-to-one interviews with a sample; and *a rounded view* by including the trainers' perspectives.

Pre-training questionnaire

2.6 The researcher developed a questionnaire for administering before the training[12]. This aimed to collect basic background information on prospective participants e.g. their role, whether they had attended any previous training in relation to recovery, and what they hoped to get out of the training.

2.7 The most significant portion of the questionnaire aimed to identify:

- prospective participants' knowledge and beliefs in relation to recovery; and
- their confidence in promoting recovery.

2.8 Knowledge and beliefs were assessed on the basis of a 'belief inventory' that the researcher developed. This comprised a series of 24 statements about recovery which were directly drawn from the learning materials on which the training was based i.e. the 10 ESCs and Realising Recovery.

2.9 The prospective participants were requested to indicate their level of agreement with each of these statements using a five point (Likert) scale - strongly agree, agree, neither agree nor disagree, disagree, strongly disagree.

2.10 Responses to Likert scales may be subject to distortion. In particular, respondents can be prone to agree with statements that are provided (acquiescence bias) or try to portray themselves in a favourable light (social desirability bias). In constructing the questionnaire, attempts were made to reduce the likelihood of scores being skewed in these ways. Thus, the inventory was developed so that for about half of the items, a response of 'strongly agree' was considered as consistent with the recovery values that the

[12] Blank copies of the pre and post-training questionnaire are available from SRN on request.

training was seeking to engender. The remainder of the items were worded in such a way that the response ‘strongly disagree’ was intended to indicate the desired recovery value.

2.11 Confidence in promoting recovery was assessed via six items. On a scale of 1 – 6 ranging from extremely unconfident to extremely confident, respondents were asked how confident they felt in relation to telling colleagues about recovery and using recovery-focused approaches.

2.12 The information on participants’ pre-training knowledge, values and confidence were intended to provide baseline information i.e. a point of reference for comparison with subsequent knowledge, values and confidence.

Administration of pre-training questionnaires

2.13 All those who signed up for training were asked to complete a pre-training questionnaire. Procedures were put in place to:

- enable these questionnaires to be completed on an anonymous basis; and
- match each individual’s pre-training questionnaire with the one that would (subsequently) be completed at the end of the training.

The details of how this was achieved are provided in the appendix to this report.

Post-training questionnaire

2.14 The post-training questionnaire was developed to obtain participants’ reactions to the training (Kirkpatrick level one) and to identify whether they had learned anything new (Kirkpatrick level two).

2.15 Thus a series of short questions were included to obtain views on the quality of the training and how relevant participants felt the training to be (Kirkpatrick level one).

2.16 To assess whether there had been any changes in recovery values and beliefs (Kirkpatrick level two), the questionnaire included the belief inventory of 24 statements that were included in the pre-training survey (as described in paragraphs 2.8 and 2.9)

2.17 Similarly, to assess whether participants felt more confident in actually promoting recovery, the post-training questionnaire repeated the questions concerning self-reported confidence in telling colleagues about recovery, and using recovery-focused approaches (as described in paragraph 2.12)

2.18 To understand the circumstances or context that might support or impede any behaviour change after the training (Kirkpatrick level three), or indeed participants’ ability to effect *organisational* changes, the questionnaire also

posed a series of questions to gauge participants' intention to share learning, and views on the extent to which their host organisations were views as likely to support and embrace recovery values and practices[13].

Administration of post-training questionnaires

2.19 The post-training questionnaires were given to participants the end of the training and were completed on an anonymous basis. Each participant was given a blank envelope for his/her completed questionnaire. These were collated by the trainer (still in their sealed envelopes) and sent to the researcher.

Interviews

2.20 It is important to stress here that the inclusion of these interviews is intended to fulfil two functions: to collect detailed accounts from individuals on their training experiences; and to understand whether they have changed their practice as a result of the training. Thus, while the interviews are intended to *complement* the questionnaire data, it is important to acknowledge that these interviews are not intended to represent the views of all those attending the training.

2.21 Depth interviews were carried out with eight participants prior to them embarking on the training. Follow up interviews were carried out with six of these[14] two to three months after the training.

2.22 All had indicated their willingness to participate in these by first returning a 'consent to be contacted' form directly to the researcher, and then by agreeing to be interviewed.

2.23 These interviewees worked in a diverse range of organisations. Some of these organisations had a remit for mental health, including supporting service users. Other organisations provided support to diverse client groups, and service users were said to figure among these. The researcher purposefully selected her sample of interviewees in order to obtain views of individuals working across this spectrum.

2.24 The pre-training interviews involved participants explaining their role within their organisation, their understanding of recovery and their expectations and wishes regarding the training.

2.25 The follow up interviews focused on: interviewees' views on the training (Kirkpatrick level one); what, if anything, they felt they had learned (Kirkpatrick level two); and whether they had done anything as a result of attending the

[13] Some of these questions (described in this paragraph) were modelled on those developed by Colin MacDuff and his colleagues at Robert Gordon University in their evaluation of the 10 ESC training.

[14] Two were unavailable for follow up: one due to long terms sickness absence and the researcher was unable to contact the other.

training (Kirkpatrick level three) and the circumstances that supported or impeded any behaviour change. Finally, the interviews explored views on whether, and if so how, the training might be improved.

2.26 The four trainers were also interviewed. These interviews took place after they had delivered three of the four two-day courses. Trainers were asked for their perspective on the training including how they thought it might be improved.

3 Findings

A note on use of terms

To differentiate between findings drawn from the questionnaires and those from interviews, in this chapter the terms 'participants or 'respondents' will be reserved for references to findings from the questionnaires.

3.1 Data from the sources outlined above were analysed in relation to levels one (reactions), two (learning) and three (behaviour) as indicated by the Kirkpatrick model. In this chapter, the key findings are presented. First however, in order to contextualise these, a brief overview is given of the profile of the participants and their hopes regarding the training.

3.2 Throughout this chapter, reference is made to a number of data tables (1 -10). These tables can be found at the end of the report in the Appendix section.

What do we know about the training participants?

Summary of key points:

The training was attended by a diverse range of individuals, many with extensive experience of working in the mental health field.

Most indicated that they held beliefs and values that were consistent with recovery.

The notion that 'Mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients' seemed to be a contentious notion for many.

Self-reported knowledge of, and confidence in using, person-centred tools and approaches was high.

Most were attending the training in order to increase or improve their understanding of recovery and to develop or refine their recovery practices.

3.3 Ninety individuals were allocated a place on the training, 73 of whom attended. Of these, 69 (95%) completed both a pre-training and post-training questionnaire. As the intention here is to provide a context for understanding the views and any changes experienced in participants due to the training, the profiling of participants is restricted to the 69 for whom both questionnaires are available. The information in paragraphs 3.4 – 3. 24 is based on analysis of their pre-training questionnaires.

3.4 The overwhelming majority of participants (n=51, 74%) indicated that they were attending the training because they work face to face with people with mental health problems. A large number (n=18, 26%) managed a team who provided this type of support[15]. Four (6%) said they had strategic responsibility for organisational systems, five (7%) were responsible for cascading information through their organisations and ten (14%) said they were trainers.

3.5 Forty three (62%) indicated that their main reason for attending the training was because they chose to do so, whereas 25 (36%) indicated that they were nominated by their manager to attend[16].

3.6 Participants were asked for how long they had worked in organisations that support people with mental health problems, and their responses indicated considerable heterogeneity in this regard. The fact that 27 (39%) indicated that they had worked in this capacity for over 10 years suggests that the training was understood to be relevant to those with considerable experience and not just newcomers.

3.7 Most (n=43, 62%) had not received prior training in recovery values and /or recovery practices. The remainder who said that they had received such training cited a number of sources including in-house meetings, SRN conferences and training in recovery (by Ron Coleman), WRAP and Scottish Mental Health First Aid.

3.8 Participants were asked what they hoped to get out of the training. Overwhelmingly, respondents expressed their hopes in terms of improving their understanding of recovery and/or hoping to learn about recovery practices. Thus, their hopes were realistic and aligned with the stated aims of the training.

3.9 Generally the responses suggested that people were coming to the training already knowing something about recovery: the language they used talked about wanting to increase or to refresh their knowledge.

3.10 Three respondents highlighted that they wanted to learn more about the 10 ESCs which suggests that they had some familiarity with the broader context for the Recovery in Practice training.

3.11 The majority of respondents also expressed a desire to develop or improve their recovery skills. A key dimension to this was a desire for practical skills or tools that they could then apply within the context of their work.

3.12 Against this backdrop of a frequently expressed wish to strengthen existing understanding and practices, a very small minority indicated that they wanted to learn about recovery and/or mental health. For example:

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[15] Some managers also worked on a face-to-face basis with clients.

[16] One individual did not provide a response to this item

'I worked with people in learning disabilities services for many years and aspects of mental health weren't explored as I think they should have been. Therefore I think I have a gap in my knowledge. I would like to look at recovery as being part of the care planning process.'

3.13 This suggests that some, albeit a small minority, were attending the training with little or no prior knowledge about recovery.

3.14 Two individuals indicated that they hoped that the training would help them with their own personal recovery.

3.15 The distribution of responses to the questionnaire items that were designed to assess the extent to which individuals held values that were consistent with recovery provided a similar picture. Overall, these revealed that most participants held beliefs that were 'in the right direction' i.e. in general terms, the majority of participants indicated that they agreed with the statements that were compatible with recovery values, and they disagreed with those statements that conflicted with recovery values.

3.16 Thus, prior to attending the training the majority of participants indicated their agreement with the following statements:

- There is no right or wrong way to recover.
- Recovery is relevant to anyone with a mental health problem.
- Mental health workers need to be able to step back at times to allow people to take control for managing their own recovery and wellness.
- It is important to maximise opportunities for all mental health service users, including those subject to compulsory powers to make choices about how they live.
- There are key things that all individuals can do to help their recovery.
- Working with service users provide opportunities for mental health workers to learn about themselves.
- I feel that it's important that mental health workers reflect on their own and others' practice to examine whether hopeful messages are being conveyed.
- Mental health workers can only support an individual's recovery if they understand what's important to him/her.
- I feel that person centred tools/approaches are useful for helping clients in their own recovery.

The fact that no one disagreed with the statement 'It is important to maximise opportunities for all mental health service users, including those subject to compulsory powers to make choices about how they live' would seem to suggest that this was the least contentious of all the statements.

3.17 For the first four of the statements above, the most common response provided was that of 'strongly agree'.

More specifically, over half (64%) indicated that they 'strongly agreed' with each of the following two beliefs:

- Mental health workers need to be able to step back at times to allow people to take control for managing their own recovery and wellness.
- It is important to maximise opportunities for all mental health service users, including those subject to compulsory powers to make choices about how they live.

Just under half of the participants 'strongly agreed' with the following two statements (48% and 45% respectively):

- There is no right or wrong way to recover.
- Recovery is relevant to anyone with a mental health problem.

3.18 Similarly, prior to attending the training the majority of participants indicated that they held recovery values by *disagreeing* with the following statements:

- Mental health workers should try to solve as many problems as possible for their clients.
- Workers should discourage people with mental health problems from talking about being sad.
- I have a pretty good what individuals need to help them recover even before I meet them.
- At all times mental health workers should minimise the risks that their clients face.
- Mental health workers should identify goals for their clients.
- It is important to let some people know that they will never recover.
- Individuals' diagnosis and symptoms are more important in planning recovery than their strengths and aspirations.
- Risk assessment is the responsibility of the mental health worker and not their client.
- The role of the mental health worker is to address symptoms rather than to understand their clients.
- It is the role of the mental health worker to tell clients what they need to do to recover.

3.19 More specifically, 'strongly disagree' was the most common response given by participants to the following statements (the percentages doing so were 54%, 44% and 55% respectively):

- I have a pretty good idea what individuals need to help them recover even before I meet them.
- It is important to let some people know that they will never recover.
- The role of the mental health worker is to address symptoms rather than understand their clients.

3.20 The statement 'mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients' stood out as being an item provoking a more ambivalent response[17]. More people (38%) indicated that they 'neither agreed nor disagreed' with this statement than gave any other response.

3.21 The majority (74%) indicated that they agreed or strongly agreed with the statement 'I am aware of a number of person centred tools that can be used to support clients': 65% 'agreed' and 9% 'strongly agreed'. The high level of agreement suggests a significant degree of knowledge regarding potential recovery practices.

3.22 The overwhelming majority (91%) indicated that they disagreed or strongly disagreed with the statement 'Asking someone if they are feeling suicidal increases the risk of the individual trying to kill himself/herself'[18]: 36% 'disagreed' and 55% 'strongly disagreed'. This item, while not directly reflecting a recovery value, could be relevant to supporting an individual in crisis. Participants' responses suggest that nearly all understood this important principle of suicide prevention.

3.23 Prior to the training, most participants described their confidence levels as lying mid way between 'extremely unconfident and extremely confident' on the basis of a six point scale in relation to the following six statements:

- Working from a recovery based philosophy.
- Undertaking a recovery based assessment.
- Using person centred tools/approaches with clients.
- Developing a recovery based plan with a client.
- Working with a challenging situation from a recovery perspective.
- Providing an overview of recovery principles to a group of colleagues.

3.24 The highest levels of confidence were in relation to the item 'using person centred tools/approaches with clients' with 70% indicating their confidence levels at '4', '5' or '6' on the scale.

3.25 'Undertaking a recovery based assessment' was the item with the lowest confidence scores: only 26% indicated their confidence levels as '4' or over.

[17] The statement 'Mental health workers should think of things to aim for' also prompted a high number of 'neither agree or disagree' responses. However, this seemed to be due this being a badly worded item, and many respondents had added comments to the effect that 'it depends'. This issue is picked up later in the report.

[18] This statement is a key message of Choose Life – Scotland's suicide prevention strategy and programme.

What do we know about interviewees?

Summary of key points:

Interviewees worked in a range of organisations, most of which were described as being generally person-centred and/or recovery-focused.

Most interviewees had a good understanding of recovery.

The views expressed by interviewees mirrored those of participants more generally.

The sample of interviewees would seem to be well balanced and therefore should usefully complement the data from the questionnaires. However, this small sample is not intended to be representative of all participants and thus their views should not be considered to be generalisable to all who took part in the training.

3.26 Six participants were interviewed both before the training and at follow up two to three months after the training.

3.27 The pre-training interviews were intended to provide a context and point of reference against which the subsequent follow up interviews could be considered[19].

3.28 Interviewees were worked in a range of voluntary organisations that varied considerably in size, geographical reach and purpose. Four interviewees worked in organisations specifically targeting (and supporting) people with mental health problems while the other two worked in agencies that supported a very broad range of people including people with mental health problems.

3.29 Interviewees held a variety of roles. Four worked in a hands-on manner with their client group, and also line managed other staff. Two others had a primary role and remit for training and learning within their respective organisations, and they plus one other interviewee talked of being trainers in Scottish Mental Health First Aid.

3.30 Most interviewees demonstrated some understanding of recovery. They talked about aspects of recovery in quite sophisticated terms. The following quotes were taken from interviews with three different individuals:

'I believe that recovery is very much about the person having control of their own recovery and it might just be a small step as opposed to a huge step that they take.'

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[19] This report does not include any interview codes against any of the comments that individuals make. This decision has been taken so that readers can not link quotes provided by a particular individual as doing so might jeopardise the anonymity that interviewees were promised.

'We can all live as best a life as we can.'

'Recovery is possible… people can recover, can fully recover, can make a level of recovery… and I suppose it's about people's ideas about what recovery is… Maybe Joe Bloggs' idea is that the person may never hear voices again. I don't think that's realistic but in terms of recovery for me, it's what the person wants – taking the children out to the park, to the swings. I see that as a step to recovery… I think recovery is different things to different people.'

3.31 While most of the interviewee accounts indicated a general understanding of what the term recovery means, some were not confident that they had a well-rounded appreciation of the issue. For example, one said:

'I am wanting to either clarify some things or confirm what I do know is actually right – or kind of be able to put aside things that I've maybe made up (laughs) along the way, if you know what I mean. I just want to clarify my knowledge and maybe add to it.'

3.32 Another interviewee talked of believing that s/he worked in a recovery-focused manner but simply used different language.

'We already work in a recovery orientated way, we support people with their recovery, but it's not a term that we use, we've always worked in a person-centred way and an inclusive way, but we don't talk about recovery as such, although that's the way we work.'

3.33 Only one interviewee felt that s/he did not know what recovery entails.

3.34 All interviewees viewed the training as an opportunity to learn more about recovery. Three specifically said that they wanted to learn more about recovery tools and techniques. One interviewee reflected on the particular challenges in promoting recovery among people with alcohol problems – a client group for whom s/he felt recovery could be very slow and beset with many setbacks.

3.35 Generally interviewees described their organisation as person centred and/or recovery focused. One however said that the challenge lay in getting the organisation to move from delivering person centred support to working in a user-led manner.

3.36 Two expressed some concerns about the capacity of their organisations to support recovery practices. One said that the organisation was 'stretched to the limit' and that this created challenges in terms of the likelihood of the organisation working to promote recovery in a prolonged and sustained manner.

3.37 The profile of these interviewees suggests that their roles, understanding of recovery and expectations generally mirrored those of the participants as a whole. While the interviewee sample was not intended to be representative of all participants, it is reassuring to note that their pre-training accounts suggest

that the sample includes an appropriate spectrum of roles and expertise, and that their expectations mirrored the most commonly expressed ones in the pre-training interviews. Therefore, there is no sense of this sample being 'unusual' and/or of the individuals holding a view that is atypical of the participants generally i.e. there is no sense that the sample here is a biased one. As a consequence, interviews with this sample should provide a useful basis for exploring views and experiences concerning the training and its effectiveness that will complement the data collected (by questionnaire) from all participants.

What did participants think of the training?

3.38 This section presents analysis of data concerning views and reactions to the training (Kirkpatrick level one). The findings are drawn from questionnaires completed by all participants at the end of the training and the six follow up interviews.

Views immediately after the training

Summary of key points:

Participants rated the training and the trainers extremely positively.

Many valued the opportunity to learn from participants and to reflect on professional practice.

There was considerable interest in WRAP.

Reservations were expressed about specific elements of the training.

Some felt that the training was 'preaching to the converted'.

3.39 The feedback from participants at the end of the training was overwhelmingly positive. The overall quality of the training was rated as 'generally very good' by 68% and as 'generally good' by a further 30%. The remaining 2% rated the quality as 'mixed'. Nobody ticked the boxes 'generally poor' or 'generally very poor'. Thus, the immediate response to the training was strikingly positive.

3.40 Similarly, at the end of the training, the overwhelming majority of participants rated the training as appropriate to their role: 93% responded to the question 'how would you rate the overall relevance of the training for you?' by ticking the 'highly relevant' option. Only 3% described the training as 'slightly relevant' and a further 3% as it being 'mixed'. No-one indicated that they considered the training to be 'not that relevant' or 'not relevant at all'. Therefore, at the end of the training, overwhelmingly participants indicated that it was appropriate to their role.

3.41 In response to the open-ended questions (where participants could write their views of the training in their own words), a number of features were highlighted as being of particular value. These qualities are summarised below.

3.42 The trainers were praised: they were variously described as informative, entertaining, personable and approachable. Furthermore, many highlighted the fact that the trainers' sharing of their personal experiences put a 'personal spin' on the issues being discussed and that this in turn made the content of the training more meaningful. A few wrote that they felt 'privileged' to hear these personal accounts. Finally, some highlighted that the trainers brought complementary skills – the issue then was that that it was good trainer mix.

3.43 Many indicated that they appreciated the opportunity to learn from others working in different organisations: the sharing of perspectives was described as very useful. The fact that much of the training was highly participative was viewed to engender this reciprocal sharing of ideas and experience. Some participants stated this was their preferred learning style.

3.44 Many had not heard of WRAP before the training and demonstrated a very high level of interest in it, feeling that the overview provided on WRAP was the most useful element of the training.

3.45 Many participants felt that the training offered a valuable opportunity to reflect on professional practice.

3.46 While the feedback provided in the post-training questionnaires was largely positive in nature (see 3.42 -3.45), reservations were also expressed.

3.47 Some participants felt that the training was 'preaching to the converted'. As a consequence, quite a few were of the view that there was too much time spent on understanding or describing recovery as this was already very familiar territory. Instead, some felt that it would have been more useful to have concentrated on practice, in particular, dealing with challenging situations i.e. influencing individuals, including work colleagues, who are not open to recovery ideas and ideals.

3.48 A few commented that the service users' personal accounts were unhelpful insofar as they were felt to be 'too narrow': the fact that their stories or experiences were so individual was felt to limit rather than illuminate understanding of key concepts.

3.49 The highly participative nature of the training was viewed unfavourably in some cases. Criticisms included: the noise level in the training room which hampered group discussion; group dynamics (with attendant frustrations over participants who either dominated group discussions or who failed to engage

with these); and participants feeling that they were at times 'put on the spot' and expected to share personal experiences[20].

Interviewees' views at follow up

Summary of key points:

The interviews provided a more detailed and also nuanced picture than that emerging from the questionnaires.

Interviewees' reactions to the training were influenced by factors such as professional role and expertise, and preferred learning styles.

The diverse range of individuals taking part in the training meant that people had very different training needs. As a consequence, the content of the training was not felt to be relevant to all those interviewed.

Some interviewees felt that group discussions were not always productive and would have benefited from a facilitator.

Some interviewees considered elements of the training as inappropriate.

Interviewees' views can not be assumed to be generalisable to all participants.

3.50 The interviews at follow up were intended to provide an opportunity to explore perceptions of the training in more depth than was possible in the questionnaires. In fact, one interviewee reinforced this, spontaneously remarking:

'I was very rushed when we were filling out the questionnaire. So I didn't really feel like I did that justice, to be honest.'

3.51 Importantly too, because the interviews were conducted two to three months after the training, these individuals had more time to reflect on the training and their feelings about it. The value of this follow up was acknowledged by some who felt that they needed time to think about the training before they could make a judgement about it:

'For me, personally, I'm quite a reflective person, so it wasn't until after the training, you know, and I've had time to digest myself, how it made me feel and what I thought about it – so I think, on the day, I probably wouldn't have been in a position, at that point, to feed that back right away like that. I would

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[20] One example here was when all participants were asked to think about a personal experience of discrimination, write down how this had felt, and then were subsequently asked to stick these notes (describing their feelings, not the incident itself) on the wall.

have needed a bit of time, you know, to go through what, just what we're doing just now – you know, what I felt was good about it, what I didn't feel so good about it and why.'

3.52 As before, it is important to set the interviews in context and acknowledge that the findings that follow are based on the accounts of *six* people[21]. To do justice to these depth accounts, the findings based on the interviews are quite detailed.

3.53 At follow up, interviewees expressed overwhelmingly positive views about the trainers. Thus, similar to the responses in the questionnaires, the trainers were frequently described as wonderful, friendly, approachable, funny etc. '*Ten out of ten'* one individual enthused on several occasions throughout the interview. Similarly they were described as engendering a good atmosphere. One said, '*the way it was presented was a good balance between focused and purposeful, but at the same time not too stuffy'*, another that the style was '*upbeat*.'

3.54 Very mixed, in fact, contradictory views emerged on the training programme. Two interviewees were extremely positive: 'I loved it, I thought it was great… I liked all the scenarios' said one, an individual who works on a face-to-face basis with mental health service users. Another who was a trainer, said that s/he liked it because it provided a space to reflect on practice as well as ideas for the future: 'When I'm on training as a participant, I am looking for ideas (laughs) to steal!'

3.55 Two, both of whom were managers, had a more neutral response to the training. Their measured responses indicated that while they did not find the training personally very useful, they could see that it might be relevant to others, particularly those who had recently started to work in care. Of these two individuals, one said that the training was of some limited personal use insofar as it reinforced what s/he already knew.

3.56 The remaining two had very negative reactions to the training: they described it as frustrating and a poor use of time, with one going as far as to say that s/he recommended that no-one else from the host organisation should participate. Importantly however, these reactions to the training were personal ones: one was keen to stress that although the training was not personally useful, this should not be taken to mean that it would be of little use to anyone. Furthermore, despite their overall negativity, both conceded however that there were specific elements of the training that had been personally useful: both highlighted the value of having reflected on the relationship between workers and users (this is covered in more depth in a subsequent section of the report). The issue then was one of the balance between the strengths and weaknesses of the training:

[21] In order to further contextualise findings, this report indicates whether a perspective was held by one interviewee as compared with, for example, 'some' or 'many' of the six interviewees.

'There were positives within that as well. It's just that unfortunately for me, the negatives kind of outweighed the positives.'

3.57 A common criticism of the training was that the content was felt to be too basic.

'I've been doing my job for ten years now, and I didn't come away from the training thinking that it was something that I would highly recommend to somebody else. I think, perhaps, if it was something, someone that was just starting within the field of mental health, and their role, then I would say yes – you know, two day training course covering quite a few topics about recovery, etc, then yes – I think it would be appropriate then. But for myself, having done this job in the field of mental health, I felt I didn't get out of it what I was hoping to'.

3.58 The issue then was one of the *appropriateness* (or otherwise) of the training for the individual concerned. Others too highlighted that the key issue is tailoring the programme to the needs of the target group, and the dilemma that the *Recovery in Practice* programme faced in meeting the needs of a diverse group of participants:

'Training's important. Recovery training is also important, but what level do you pitch it at and what's the content is the important part – and certainly I'm there finding a lot of it had been covered before in other organisations under different titles, and I think some of the colleagues I was along side were finding it much the same, yeah.'

Two suggested that the training (like any other training programme) should first establish what people already know, and then seek to 'plug the gaps'.

One interviewee (a trainer) suggested that to meet the needs of trainers, a 'training for trainers' programme might have been more useful.

3.59 Despite inevitable differences in the levels of pre-existing knowledge that participants would be likely to hold, interviewees believed that many people in the voluntary sector are already working in a person centred manner, and most (but not all) of those interviewees who had worked for many years in social care and/or mental health felt that the training did not offer them much that was new.

3.60 Some interviewees highlighted that effective promotion of recovery involves changing working practices, and therefore the best placed people to put recovery into practice are those working on a face to face basis with the client group. This caused some interviewees to reflect whether they were the right people from their organisation to be attending the training especially in view of its very experiential content and its focus on how to engender recovery in individuals (as opposed to services).

3.61 Those who were highly experienced in using person-centred planning tools said that the exercises on using these were inappropriate: it was felt that insufficient time had been allocated to the training exercises, and that a little

knowledge can be harmful. For example, one individual reflected on the *Recovery in Practice* input on person centred planning tools in comparison with previous training on the use of these:

'I spent a week doing person-centred planning, doing gift posters, doing paths, doing maps, dreams, you know a whole week of intensive training, and all we did (in Recovery in Practice) was an hour, and then hand outs. I think it's, yeah, I think it is quite dangerous, you know, to just introduce it, so much, there was a huge amount to introduce and, and as you say people might go away thinking that they know about person-centred planning, what we've done is, just introduced it briefly. That's what I mean it could be quite dangerous.'

Thus despite the fact that the training attempted to simply *introduce* participants to person-centred tools, there was a concern that participants may have come away from the training thinking that they were now able to use them.

3.62 For those who viewed the training as too basic, there was a feeling that the training should have been balanced to concentrate on issues that were likely to be *new* to participants and to enable more opportunities for *reflection*:

'I think the two days for that type of training, for me, was too long. So, in terms of that, I think quite a lot of the content, for me, would need to be revamped and summarised so that we didn't spend quite as much time looking at certain topics that were things that you cover on a daily basis in your role. I think there could have been quite a bit of summarisation.'

'I think we tried to fit quite a lot into two days and because there was a lot of task work within that, I felt that the training moved along quite quickly. You would have a spate of discussion, and then you were straight on to doing a task. So I don't think that you did have an awful lot of time to sit and reflect on your own practice.'

Some suggested that a shorter and more *focused* course would have been more appropriate. Nevertheless two participants felt *more* time should have been spent on the 10 ESCs and on the Recovery Indicator, and all said that they would have preferred to hear more about WRAP.

3.63 To some extent, feelings about the training were related to preferred learning styles. So, those who said that they generally enjoyed participative exercises and found this an effective way to learn were more positive about the training:

'They (the trainers) suited different learning styles if you like. They started off, you know they had kind of energisers if you like for you know, people who wanted to get up and move around. Kept it interesting. There was some theory, usually on slides. There was some talking, but generally the talking was relaying back again to maybe personal experiences, or you know interesting stories, rather than - you didn't tend to feel, bored at any time, if that makes sense. The presentation style suited me, as a learner.'

By contrast, a couple of interviewees said that their preferred learning style involved more time for individual reading and reflection, and for this reason were less enthusiastic about the training experience:

'Well, my general preference for training, I think, is probably different from a lot of people. I tend, myself, to prefer – I mean, whether I learn from it as well or not, I'm not sure – but I think I do, is if I'm kind of just given lots of information, rather than doing participatory exercises so much – although you can still learn from that – I prefer to just be given information. So I would say that was probably what I would have preferred, overall – but that tends to be the case with most training these days.'

3.64 Several interviewees talked of valuing the opportunity to meet and learn from others. Overwhelmingly they expressed a preference for 'live' training to, for example, being offered online materials with all but one saying that they valued opportunities to come together with people from other organisations and learn from each other.

3.65 One highlighted the valuable contributions made by those participants who were service users. However, this was balanced with the concern that at times service users attend with different expectations about what the training is intended to achieve, viewing the training as a means to help their own recovery.

3.66 While many valued learning from one another, the diverse range of participants was described as creating some difficulties: a number of interviewees talked of their frustration over group dynamics when engaging in (group) exercises saying that some participants talked too much and other did not talk at all, for example, saying that they did not know anything about the topic under discussion. In part, this might have arisen because the tasks were felt to be very health oriented, making it difficult for those working in more holistic roles to join in.

3.67 Such dynamics were described not only as frustrating but as '*taking away*' from the training.

'I do like group training, but as long as everyone's contributing equally within that – and I didn't find that on this course. And I did find that quite a lot was missed because of that, and I also found that my concentration and my focus waned as well, because I didn't really think we were, a lot of the time, doing what we were being asked to do. I felt there was quite a distinct lack of listening skills, at times – which had an impact on myself.'

In view of these difficulties, two interviewees felt that the group discussions would have benefited from having designated facilitators.

3.68 All interviewees recognised the value of reflecting on personal experiences in order to understand and apply a recovery principle to a real life situation. *'It makes more sense to you then*' said one. Most too were quite confident in their ability to choose what to disclose and what not to:

'I mean the thing is, you'll share what you want to share and you won't share something if you don't have to. And nobody would know, whether you were sharing something that was real or not. And certainly I- and perhaps it's because I'm a trainer I'm more comfortable with things like that, I don't know.'

However, two were upset about the way this had been handled in the training. First, there was a feeling that the trainers had not respected the fact that at the outset several participants had said that they did not want to speak out in front of others, and so this had led to a feeling that they were not being heard. Second, there were instances where the exercises had evoked difficult feelings, and individuals could feel that they were just left to deal with these themselves:

'They did stipulate, within the training, you know, don't touch on things that are still emotive for you, but to look at some situations that you might have been in yourself. I think, as soon as you start to think of situations you've been in yourself, that does immediately take you back to the emotion of that time – and I felt, sometimes, that you were just left with those feelings, and I found that quite difficult to then just move on from that, you know, straight into something else.'

Thus, despite the fact that throughout the two days, the trainers stressed the importance of participants taking responsibility for their own safety (only sharing information that they felt comfortable to disclose), two of the interviewees felt uncomfortable about how the emotional impact of some of the exercises was managed.

3.69 It is notable that the reactions to the training expressed in these interviews provide a more mixed picture than that provided by the analysis of the questionnaires. However, while interviewees' reflections highlight areas of perceived weakness in the content and delivery of the training, all interviewees' feelings and reactions to *recovery* as a guiding principle were extremely positive throughout.

Was the training effective?

3.70 Kirkpatrick level two addresses the following questions - did participants find out anything new? If so, what insights/knowledge did they gain? In essence then, the question here can be framed as 'was the training effective in meeting its learning outcomes?' i.e:

- greater understanding of recovery values and recovery focused practice; and
- increased ability to reflect on and develop personal practice.

Findings in relation to these inter-related questions are presented below.

Changes indicated by questionnaire responses

Summary of key points:

The findings are based on descriptive statistics and not on (statistical) tests of significance.

There was some evidence that the training resulted in strengthened recovery beliefs and values, notably in relation to promoting hope, the individual nature of recovery, and the importance of working with service users in ways that are supportive and empowering.

The training resulted in a positive, yet modest, change in attitudes to the notion that 'Mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients'.

Examples of strengthened beliefs were not just restricted to a few participants: most participants demonstrated more strengthened beliefs than weakened beliefs.

The belief inventory that was developed for this evaluation, while not perfect, seemed to successfully identify (some) change and therefore has some validity.

The training resulted in increases in (self reported) confidence in using recovery focused approaches and in telling colleagues about recovery.

3.71 Participants' values and beliefs were assessed using the same inventory that they had completed prior to the training. It is important to acknowledge here that the scope for positive change was limited however because at the outset (before the training) many participants already held values and beliefs that were consistent with recovery principles. It is also important to note that the findings that follow are purely descriptive: they are not based on any tests of (statistical) significance.

3.72 Consideration of the responses of participants as a whole nevertheless suggests that the training was effective in strengthening recovery beliefs: looking at the modal scores (i.e. the rating most commonly assigned to each item)[22], positive change was evident for the following eight items:

- Workers should discourage people with mental health problems from talking about being sad.
- Mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients.

[22] See table three in the appendix

- Individuals' diagnosis and symptoms are more important in planning recovery than their strengths and aspirations.
- There are key things that all individuals can do to help their recovery.
- I feel that it's important that mental health workers reflect on their own and others' practice to examine whether hopeful messages are being conveyed.
- Mental health workers can only support an individual's recovery if they understand what's important to him/her.
- I feel that person centred tools/approaches *are useful* for helping clients in their own recovery.
- It is the role of the mental health worker to tell clients what they need to do to recover.

3.73 For seven out of these eight items, the movement reflected a positive change in strength of agreement or disagreement i.e. there was evidence that the training had largely reinforced existing values or beliefs.

3.74 Importantly, for one item - 'mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients' – there was some evidence of a positive shift or change: the modal (most frequent) rating moved from 'neither agree nor disagree' to agree. Since this was the only item for which the balance of responses did not 'lie in the right direction' before the training, this finding provides some support for the training's effectiveness in engendering change on this item. However, as 18 (26%) remained undecided on the issue (neither agreeing nor disagreeing with the statement), the change, while encouraging, is nonetheless a modest one.

3.75 Individuals' responses were also compared for each item i.e. their pre-training questionnaire was matched with their post training one in order to assess how many individuals demonstrated a change in the desired direction or otherwise[23]. It is important to acknowledge that such changes largely involve strengthened rather than a 'turn around' or reversal of opinion.

3.76 Thirty eight people (55%) exhibited a positive shift for the item 'I am aware of a number of person centred tools/approaches that can be used to support clients in setting goals'. This item reflects improved knowledge, and more people demonstrated a change on this statement than any other. The associated value was 'I feel that person centred tools/approaches are useful for helping clients in their recovery' and 32 (46%) indicated a more positive response to this post training than they did prior to attending.

3.77 The belief or value for which the greatest number of participants exhibited a positive change was 'Mental health workers should be willing to share aspects

[23] See table four in the appendix

of their own lives to inspire hope and recovery in their clients': thirty six (52%) provided responses that indicated more agreement with this item. It is notable that the item for which the next highest number (32, 46%) exhibited a change was 'Working with service users provides opportunities for mental health workers to learn about themselves' as this item also concerns the nature of the relationship between service users and those who support them.

3.78 There were some items for which quite a few participants' responses seemed to move in the 'wrong direction' after the training. There are three reasons why this might have occurred: the training effected these changes, the item is badly worded and/or does not measure change, or any change that has occurred could be due to chance. This latter possibility could equally apply to those items for which (positive) change has occurred.

3.79 Certainly the patterning of responses would seem to imply that the overwhelming majority of the items are worded appropriately: in general terms, the distribution of responses and the direction of change that is evident for each of the scores suggest that the items have some validity (i.e. they reflect recovery values) and are sensitive to change.

3.80 The exception to this is the item 'mental health workers should think of things for service users to aim for'. Both before and after training the most common response to this statement was 'neither agree nor disagree'. Furthermore, both before and after training, the numbers agreeing and the numbers disagreeing with this statement were high. On reflection, the wording of this item is confusing. Originally it was intended to gauge whether participants believed that service users should set their own goals, but the actual wording used here does not adequately address this belief: a belief that workers should think of things for a service user to aim for does not run counter to a belief that service users should identify their own goals. Therefore this item is not included in subsequent analyses.

3.81 In view of the possibility that some change is simply due to chance, it is instructive to also consider the extent to which responses moved in a positive direction as compared with the extent to which they moved the other way i.e. for each item, how many more participants indicated stronger recovery beliefs compared with those who indicated weaker recovery beliefs[24] .

3.82 Considering the data in this way indicates again that most change was evident for the items reported in paragraphs 3.63 and 3.64 i.e. 'I am aware of a number of person centred tools/approaches that can be used to support clients in setting goals', 'I feel that person centred tools/approaches are useful for helping clients in their recovery', 'Mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients' and 'Working with service users provides opportunities for mental health workers to learn about themselves'.

[24] See the last column in table four in the appendix

3.83 There were other items that showed a marked change too insofar as large numbers of participants indicated that after the training their beliefs were more strongly aligned with recovery beliefs, and that the numbers showing such change far exceeded those whose post-training recovery beliefs were weaker than their pre-training ones. In turn, these findings (reported in paragraphs 3.81- 3.84) suggested some evidence of effectiveness in strengthening key recovery principles.

3.84 There was some evidence that the training led to strengthened beliefs in promoting hope:

- twenty nine (42%) demonstrated stronger disagreement with the item ‘it is important to let some people know that they will never recover’ compared with just eight (12%) who disagreed less with this statement after the training.

3.85 There was some evidence too that the training led to strengthened beliefs regarding the highly individual nature of recovery:

- twenty six (38%) demonstrated stronger agreement with the item ‘there is no right or wrong way to recover’ compared with only five (7%) who agreed less with this statement after the training;

- twenty five (36%) demonstrated stronger agreement with the item ‘mental health workers can only support an individual’s recovery if they understand what’s important to him/her’ compared with only six (9%) who agreed less with this statement after the training.

3.86 Evidence that the training led to stronger beliefs about the value of supporting and empowering clients in their recovery came from the following findings:

- twenty eight (40%) demonstrated stronger disagreement with the item ‘mental health workers should try to solve as many problems as possible for their clients’ compared with only five (7%) who disagreed less with this statement after the training;

- twenty nine (42%) demonstrated stronger disagreement with the item ‘mental health workers should identify goals for their clients’ compared with only five (7%) who disagreed less with this statement after the training;

- thirty (43%) demonstrated stronger disagreement with the item ‘it is the role of the mental health worker to tell clients what they need to do to recover’ compared with only seven (10%) who disagreed less with this statement after the training.

3.87 Responses to the ‘I have a pretty good idea what individuals need to help them recover even before I meet them’ ran counter to this latter finding: while 15 (22%) showed more agreement with this statement, nearly as many - 11 (16%) showed more disagreement after the training.

3.88 Notwithstanding some of the anomalies that emerged however, the pattern of responses suggests that the training was associated with a strengthening of recovery knowledge and beliefs, and that this was more marked in some items than others.

3.89 While the analyses above suggests that the training was associated with strengthened understanding of, or agreement with, recovery principles, it does not tell us whether the changes in ratings were evident across all participants, many participants, or just a few i.e. it is conceivable that the changes in ratings were confined to under half of the participants. To explore this issue, for each individual participant, their response to each item was compared with the response that s/he gave to the same item at the end of the training.

3.90 Comparison of the pre- and post training scores indicated a positive change in at least one item for all but one of the participants (99%). However, this in itself would represent a very blunt assessment of the effectiveness of the training: by chance alone one might reasonably expect a change in ratings to some of the items.

3.91 Encouragingly, many participants provided ratings that were more consistent with recovery across many different items. the distribution of these scores[25] can be divided into quartiles (quarters), with this indicating that:

- 75% of participants provided ratings on *five* or more items that suggested they had stronger recovery values after the training than before;
- 50% of participants provided ratings on *seven* or more items that suggested they had stronger recovery values after the training than before; and
- 25% of participants provided ratings on *ten* or more items that suggested they had stronger recovery values after the training than before provided ratings.

3.92 The figures above might be considered to provide a rather distorted view insofar as they do not reflect the possibility that while some recovery beliefs might have become strengthened, others might have become weaker. Therefore, for each participant adjusted values were computed to take account of this. These adjusted or ‘net values’ involved totalling up the number of items for which a positive change emerged and subtracting the number of items for which there had been a negative change for each participant[26].

3.93 This more conservative assessment of the effectiveness of the training in strengthening recovery beliefs indicates:

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[25] See table five in the appendix

[26] The distribution of these net values is shown in table six.

- 85% had a greater number of strengthened than weakened or no-change beliefs.

3.94 Consideration of the quartiles (i.e. by dividing the data into four equal parts) indicates that:

- 75% had *two* or more strengthened beliefs than weakened or no change ones;
- 50% had *five* or more strengthened beliefs than weakened or no change ones; and
- 25% had *eight* or more strengthened beliefs than weakened or no change ones.

Thus, the training was effective in strengthening *some* beliefs in most participants.

3.95 The magnitude of change on any given item, while variable, typically involved moving one 'point' on the scale e.g. from 'agree' to 'strongly agree'[27]. This suggests that most changes took the form of reinforced rather than transformed beliefs. Just 6% of responses for the belief items involved a positive change of a magnitude of two or more points.

3.96 The analyses above did not include the knowledge item - 'I am aware of a number of person centred tools/approaches that can be used to support clients in setting goals'. The responses of thirty four (49%) participants indicated increased knowledge on this factor. The responses of four (6%) however seemed to suggest a decrease in knowledge.

3.97 While the preceding few pages have reported on analysis from the belief inventory scale, responses to the open ended items in the questionnaire also indicated that many participants felt that they had benefited from the training in ways that suggest that the training was felt to be effective: many wrote that they had learned and/or intended to be 'more person centred' or 'more recovery focused'. These comments chime with, and thereby reinforce the findings based on the analysis of participants' ratings of the recovery beliefs.

3.98 The post training questionnaire repeated questions to identify how confident participants felt across a range of recovery issues and actions. On a scale of 1 – 6 ranging from 'extremely unconfident' to 'extremely confident', respondents were asked how confident they felt in relation to telling colleagues about recovery, and using recovery-focused approaches[28].

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[27] The following examples provide further clarification on this issue: a change in rating from, for example, 'disagree' to 'agree' or from 'neither agree nor disagree' to 'strongly agree' would be two points. Similarly, a change from, for example, 'strongly disagree' to 'agree' (or vice versa) would be three points.

[28] Table seven in the appendix shows the distribution of responses.

3.99 A considerable shift in confidence was evident across all six issues:

- Working from a recovery based philosophy
- Undertaking a recovery based assessment
- Using person centred tools/approaches with clients
- Developing a recovery based plan with a client
- Working with a challenging situation from a recovery perspective
- Providing an overview of recovery principles to a group of colleagues.

3.100 Whereas before the training most participants described their confidence levels as lying midway between 'extremely unconfident and extremely confident', after the training, the overwhelming majority rated their confidence above the mid point level.

3.101 Furthermore, across each of the items, there was a positive shift in the rating most commonly given by participants. For four items, more participants indicated a confidence level of '5' than for any other rating. The magnitude of this shift was marked: an increase or shift in confidence by two points emerged for 'working from a recovery based philosophy', 'developing a recovery based plan with a client' and 'providing an overview of recovery principles to a group of colleagues'. An increase or shift in confidence by one point emerged for the remaining items.

3.102 Looking at the confidence change on an item by item basis, it was evident that the overwhelming majority of individuals felt that their confidence had increased[29]. The numbers indicating increased confidence ranged from 40 (58%) for 'using person centred tool/approaches' to 51 (74%) for 'undertaking a recovery based assessment' and 'working with a challenging situation from a recovery perspective. For the item 'working from a recovery based philosophy', only one individual had scores that suggested a drop in confidence after the training. For the other items, the scores of between three (4%) and six individuals (7%) indicated a drop in confidence. Thus the very clear picture is one of increased confidence across all items after the training.

3.103 Most individuals indicated that they felt more confident across most of the items: over half of the participants (39, 56%) had scores that indicated increased self confidence over five or six of the items. The breakdown of this information is provided in table nine. Five (7%) exhibited a decrease in confidence[30].

3.104 These feelings of self-confidence were reflected in the comments that participants made in the open ended sections of their questionnaires. Many wrote that they now felt more confident in terms of their understanding of

[29] Table eight in the appendix provides a breakdown of the number of participants whose responses indicate improved confidence across each item

[30] This last finding is not included in table nine.

recovery principles and how these might then be applied in their work. For example:

3.105 'I feel more confident and forthcoming in asking directly and primarily to the individual "what do you think would help you to recover?" and I feel more confident in relaying this to my team'.

3.106 One other theme emerged time and time again in the feedback that participants provided in their questionnaire: WRAP. Many individuals wrote that they had not heard of WRAP before and that they thought that WRAP would be a useful tool to use in their work.

Interviewees' accounts of what they learned

Summary of key points

Recall about the content of the training was very poor and interviewees' responses need to be understood within the context of a guided interview.

Most felt that the training had reinforced what they already knew from their person-centred practice yet also identified some learning/insights.

Most had not heard of WRAP before the training and all were very interested in it.

3.107 The follow up interviews provided an opportunity to explore views on what had been learned in the training. As such, these were self-reported gains in knowledge and skills, and personal views on the utility of any new learning.

3.108 As before, it is important to acknowledge that these six interviews were not intended to be representative of the views of all who attended and so findings can not be generalised to all participants.

3.109 One interviewee was extremely enthusiastic about what s/he had learned from the training:

'For me, I didn't really know much about recovery in a- it was kind of intangible to me, before I went there, and it kind of made sense of it for me if you like. At the time. Although I can't really remember much, at the time I thought right, I know what this is about now. And I liked that about it. It made sense for me.'

In terms of the six who were interviewed however, this individual was unusual in expressing the view that the training had a transformational effect on his/her understanding of recovery.

3.110 In contrast, the most dominant theme in relation to learning was interviewees' belief that the training had reinforced what they already knew. This quote is illustrative of this frequently expressed view.

'I think it does serve a purpose as a refresher, but I do think, perhaps, that it would be of more relevance to people, perhaps, coming into care, or having, perhaps, less understanding of care. … We all know that we have an understanding to promote choice, dignity, you know, all these sorts of, you know, buzz words that arise with the Care Commission – and you know, everybody lifts some of that stuff and puts it into their own aims and objectives and, you know, their own company blurb. We all know that these things are important, that you know, allowing the service users an opportunity to dictate their own support and how it's gonna be delivered, and at their pace, etc, etc – and taking risk and all that sort of stuff. You know, so it's not, to me, it's nothing new.'

3.111 While the account above was provided by an individual working in mental health, others (including those with more generic remits) echoed the view that much of the training simply reinforced what they knew from their person-centred practice.

'I think one or two people were saying, "we've done this, done that." And I do think, you know, I do think there's a lot of it in there that is, you know, older models of person-centred support, or you know, person-centred recovery. But it just, you know, at times, it comes across as old ideas under new headings, if you like, yeah?'

3.112 It is important to acknowledge that just because some felt that the training had, in the main, simply reinforced what they already knew, this is not to say that this was not valuable:

'I thought a lot of it was kind of like revision for me. I would say that it kind of did, I mean it was useful in that it reinforced, I suppose, my general philosophy and approach to working with people, and so I wouldn't say that I really learned a lot new I don't think. But it was, you know, it was still worthwhile in a sense, kind of revising and refreshing and reinforcing overall.'

3.113 The fact that most interviewees felt that the training largely reinforced what they already knew nevertheless left room for new learning or insights. Even those who were most critical of the training overall, conceded that there were components that gave them a different perspective. This lengthy extract from an interviewee who was very negative about the training overall illustrates how certain components encouraged quite detailed reflections on the implications for professional practice. So while this individual's reaction to the training was generally negative (in fact, s/he commented that there was insufficient opportunity for reflection), there was evidence to suggest that this interviewee did nevertheless benefit insofar as s/he developed deeper insights into certain processes that underpin or support recovery. It is noteworthy that one these centred on the issue regarding boundaries between workers and users – the

recovery belief that was identified as the most contentious one in the pre-training questionnaires.

'We discussed things about identity – a person's identity, and I found that section particularly useful. Also, the bit about relationships and the boundaries in relationships, and in terms of, your own practice about getting alongside a person, rather than on their side. We talked quite a bit about that, you know, about when it's appropriate to share things about yourself. And I think that's always a bit of a grey area in practice – so those parts of the training, I found very useful. Also about the relationships, you know, the kind of positive and negative disclosure, and just about what is recovery – defining what that is for people, and risk taking. Those were all elements of the training that I did find you know useful in the job that I'm doing myself, and made me re-evaluate – do you look at the identity, or do you get sucked into that, "this is the person's illness, and that's what defines them"? So in terms of that, I found that part of it really good for myself, personally, in the job that I do, and it has made me reflect on what I do when I'm working with people.'

3.114 Because the interviews took place two to three months after the training, they provided a very useful opportunity to explore what insights had been maintained/ retained. The findings reported above provide examples of some of these.

3.115 While the interviews do provide examples of particular exercises that were effective and insights that individuals felt they 'took away with them', by and large any learning and knowledge seemed, at best, to be quite fragmented however. This may not be much of a problem: it may be that people remembered the bits that they needed to/the aspects that were new to them:

'It was- you know reinforced a lot of bits and pieces that I knew but also there was other bits that was quite informative. And I think that's what I welcomed, plus there was other bits that are really quite interesting as well. That was the WRAP, they touched on the WRAP training and things like that, and that sounds really good as well you know, so there's bits and pieces that you know I'd heard about but wasn't really kind of totally sure about it…'

3.116 However, it was notable that throughout the interviews, interviewees felt they needed to have the training materials in front of them to comment on the training or the interviewer needed to prompt/remind individuals about the content of the training. Thus, the responses that interviewees gave, in particular, those regarding the new insights that they say the training provided, must be understood within the context of a guided interview. In turn, this raises the possibility that (at best) only very little of the learning was retained at follow up. The following extract (taken from the interview with the individual who showed most enthusiasm for the training) would seem to support this:

'If your boss was to call you in and say, we sent you away on these two days. I know you found them really interesting, but what have you taken away? What would you say?' [Interviewer]

'I would say I can't remember anything, or much of anything. But that's not to say that I don't think it's worthwhile. Yeah. …As I say I've put it out of my head since.'

'Did the training provide a good space for you to reflect on your own practice?' [Interviewer]

'Mmm. Did I reflect on my own practice? No, not really. Not really I don't think. Can't really remember but it doesn't ring a bell.'

3.117 The issue that emerges here, and which is picked up in the next section of this report, is whether there was any evidence to indicate if insights gained from the training informed interviewees' subsequent thinking or practice i.e. was the learning used in any way?

3.118 The final point to be reported before leaving this section is about WRAP. Mirroring the feedback provided in the questionnaires, the interviewees demonstrated a keen interest in WRAP. Most said that they had not heard of WRAP before and those who had, said that they learned more about it, in particular that WRAP training was available. Some said that there were elements of WRAP that they could incorporate in their person centred planning, specifically agreeing goals and an action plan to achieve these.

What had interviewees done as a result of attending the training?

Summary of key points

Very few had referred to the materials or sources of information provided at the training.

Organisational imperatives and instability and time were cited as significant barriers to changing practices.

Four interviewees talked of being more attuned to recovery after the training and of this giving them a fresh perspective that they applied to their work.

Two provided tangible examples of 'following through' on their interest in recovery and attributed this to the training.

3.119 To set the above question in some context, this section starts with a brief analysis of participants' ratings on four statements[31] in the post training questionnaire. As such, these statements were intended to provide some indication of the potential contribution that participants might make in influencing the values and practices of their host organisations.

3.120 The four statements were:

[31] Some of these statements were modelled on those developed by Colin MacDuff and his colleagues at Robert Gordon University in their evaluation of the 10 ESC training.

- I intend to share what I have learned with others in my organisation
- My organisation has appropriate support in place to allow me to apply what I have learned on the training
- I feel that I can influence the recovery values of my organisation
- There is a commitment to recovery among the senior managers in my organisation.

3.121 Participants were asked to rate their level of agreement with each of these statements using a five point (Likert) scale ranging from 'strongly agree' to 'strongly disagree'. The distribution of the ratings for each of these statements is shown in table ten in the appendix.

3.122 Generally, participants' responses suggested a cause for optimism: virtually all who responded indicated that they intended to share what they had learned at the training. Similarly, the overwhelming majority indicated that they 'agreed' or 'strongly agreed' that they had the potential to influence their organisations' ethos.

3.123 Participants' responses also suggested that they felt that their organisations were likely to be supportive of, and receptive to, recovery values and practices. The overwhelming majority 'strongly agreed' or 'agreed' with the statements 'my organisation has appropriate support in place to allow me to apply what I have learned on the training' and 'there is a commitment to recovery among the senior managers of my organisation'.

3.124 A further bit of context comes from the interviews: we know that of those interviewed, four worked in a hands-on manner with their client group, and also line managed other staff while the other two had a primary role and remit for training and learning within their organisations.

Interviewees' accounts of what they had done since the training

3.125 Three interviewees had looked or glanced at the materials they were given at the training – the participants' pack (that was developed for the training) and the Realising Recovery Learning Materials (a ring-bound folder comprising six training modules). Of these, only one said that s/he had used them. The fact that this was an interviewee who had been highly critical of the training reinforces a point made earlier in this report: the fact that some individuals were very negative about the training overall does not mean that they rejected recovery principles or that they felt that all elements of the training were of little value.

3.126 This one individual who attempted to use the materials and further recovery discussion within the organisation faced significant obstacles:

'I was virtually stonewalled to be honest by managers, those (ESCs) were not, wasn't high on their agenda……All the things as I've said to you before, all the things that we talked about on those two days we already do, but we don't package it, "This is Recovery".'

'So why would you be stonewalled then if it's already kind of consistent with your ethos?' [Interviewer]

'Oh, because folks say that's fine, we heard it all before.'

'Right.' [Interviewer]

'Sorry, they're just the same way I am, you know as I said, I've done this before, but, what are the messages that we're not getting over as an organisation is that, we are a recovery organisation, that's what we're not getting over.'

'To the management?' [Interviewer]

'If you mention the word person-centred planning to everybody, "oh yeah we all know about that that's what we do, blah blah blah". If you mention inclusion to anybody "yeah, yeah, that's what we do", but you mention recovery and they all look, "nah, what's that about?" '.

3.127 The barriers that this individual faced in discussing and attempting to promote recovery seemed to arise because of difficulties in communicating to colleagues the difference (and added value of) recovery values and principles over person-centred ones. It is this very distinction that interviewees seemed to grapple with in the training itself: the fact that many felt that they had learned very little because they were already working in a person-centred manner underlines the challenges in not only communicating the difference between recovery and person centred approaches but more fundamentally in understanding the difference too.

3.128 The other issue or barrier that this individual faced in trying to promote recovery was the sense of being a solitary voice at the 'wrong level':

'I'm one of many within the organisation, I can only put forward my experience and my knowledge, I'm, I can't say "this is what we are going to do"'.

3.129 This might be seen to imply that effective championing for organisational change might require backing from some level of 'critical mass' and/or from those holding senior positions within these organisations.

3.130 Time however was highlighted as the most significant barrier to revisiting the learning materials or taking any action in relation to any learning. It was not a case of interviewees feeling that they did not agree with the recovery values that had been promoted: it was simply a matter of not having the time to take things forward:

'It's not to do with I'm not interested, cause I am interested. Just the time factor.'

3.131 Prior to the training, the issue of organisations being 'stretched to the limit' had already been stressed, with this seeming to have far-reaching implications for the feasibility of changing practices, especially to ones that are considered

to be resource-intensive. And within this, supporting individuals in their recovery – particularly those with challenging and entrenched problems such as alcoholism – while being viewed as desirable, was considered to be extremely time consuming:

'We all do want to work in that (recovery) manner – however I still feel that, you know I felt this for a number of years, that the stumbling block is the time that you can allocate you know to that sort of process.'

3.132 Interviewees highlighted the fragility of their organisations as an issue that posed significant challenges, not least in the time and energy that was involved in making a business case for their continued funding, in restructuring, applying for new jobs etc.: three cited these factors as their reason for not being able to revisit or progress recovery in the way that they would have liked. At the end of the day, their decisions were based on a process of prioritisation. For example, one interviewee talked of wanting to develop a matrix to monitor, measure and demonstrate the effectiveness of the organisation in promoting recovery yet due to more pressing priorities was unable to do this.

3.133 Despite the fact that most had not been able to do bring about large scale or systemic change since attending the training, four talked of the training resulting in them being more attuned to recovery. For example:

'The training keeps the recovery process in your head and it keeps the importance of identifying it in your head. ….So it has kept it in my mind.. It (the training) has reinforced the importance of it (recovery) and how it links into what XXXXX (Council name) are looking for from us, and what we need to evidence'.

3.134 More significantly, two interviewees provided tangible examples of following through on their primed interest in recovery. The fact that they attributed this to the training adds credence to the interpretation that the training did indeed have some, albeit modest, effect on what they did. For example:

'*I think the main one, for me, is round about identity because I think we all get institutionalised in doing our jobs – and I think it's very easy that, in terms of when you're day in and day out working with people that have mental health issues, that you do sometimes lose sight of the person, you know? Because you're so caught up in that they've got a diagnosis – but they're caught up in that as well, you know, in terms of that's what their life's revolved around, to get benefits or, you know, to access services – they have to have a diagnosis or this label. And because of that it's very…, you can lose sight of the actual person themselves. I think that the training's very much brought that to the forefront for myself, and for the staff in the project – and it's about getting more involvement from the person when we're doing our one-to-one work with the service user….before, I would maybe have taken quite a lead in that, but now, it's about trying to get the person to open up a bit about what they want in that, themselves.'*

3.135 Thus, while there was some limited evidence that the training resulted in most of the interviewees seeing their work and their clients from a slightly different viewpoint or angle, their ability to effect change was constrained by organisational factors and external pressures. The types of changes that could most easily be made were the ones that the individuals themselves could effect and which did not rely on the actions of others within their organisation who had not been on the training.

Trainers' views

Summary of key points

One-to-one interviews were conducted with four trainers.

The training was viewed as more likely to have reinforced (rather than altered) values and reaffirmed (rather than changed) practice.

There were inherent challenges in delivering training to a diverse group and prior information on their needs would have helped tailor the programme more appropriately.

There should be more consideration paid to how the training might engender (and support) changed practices. This will require thinking through who the training should target.

While the flexibility of the training was one of its key strengths, it would nonetheless benefit from being more focused. This will require removing some elements of the programme.

3.136 One-to-one interviews were conducted with the trainers after three of the training sessions had been delivered. Four trainers had been involved in the delivery of these sessions and all were interviewed. The findings below are based on analysis of the four interviews.

3.137 A number of guiding principles were described as underpinning the training. These were: recovery happens; there are significant steps that individuals and organisations can take to ensure that it happens and that these require particular *values*; and that everyone can improve their recovery practices and so it is important to *reflect* on one's values and practices.

3.138 This latter issue of practitioners *reflecting* on values was a common theme across trainers' interviews. Trainers were agreed that it was not their role to 'pontificate' or to 'criticise'. One said that the challenge lay in striking the right balance, making the training thought-provoking while at the same time ensuring that participants did not feel threatened.

3.139 There was a shared belief that the training was unlikely to have transformed values and beliefs: only rarely would people have a '*road to Damascus*' experience. Instead several said that the training was likely to *reinforce* existing attitudes. One suggested that '*to an extent, we are preaching to the converted in the voluntary sector*'.

3.140 Furthermore, a couple of trainers said that the people most likely to benefit from the training were those who already had some understanding of recovery practices. The fact that '*the people most committed to recovery learned the most*' was highlighted as something of a paradox.

3.141 It was therefore felt that while the training *may* shift values, it was '*more about affirming good practice than challenging bad practice*'. Within this, there was felt to be scope for participants to reflect on what they could do differently too.

3.142 The trainers had different things to say about the diverse range of participants who took part. There was a view that a mixed group engenders more energy and lively discussion than might develop in a more homogeneous one, and has the further advantage of bringing together a range of experiences that enable participants to look at their services and practices from different perspectives. However, it was felt that the training was hard for people who are not working in the mental health field, in part because the language is unfamiliar to them.

3.143 Trainers had different views about whether service users should be part of the mix attending this training. Some felt that service users' participation was important in order to maintain the 'voice of lived experience' and as a way of letting service users know that they are valued. It was therefore important that the trainers '*keep them safe*'. Others how however pointed out that the training materials were specifically developed for practitioners, and so the training was not directly relevant to the needs of service users.

3.144 While there was a belief that the training offered '*something for everyone*', there was also a feeling that it would have been preferable to have targeted the training more sharply, and invited a smaller number of 'like minded' organisations to attend. This, it was felt, would have helped focus the discussions that took place within the groups.

3.145 There was a belief that while participants may have left the training '*on a high*', they may have struggled with actually putting what they learned into practice. Different solutions were suggested including encouraging people to support each other and organising a follow-up forum six months after the training so that participants could gather and discuss the challenges they had faced (and how these could be overcome).

3.146 There was a recognition that a culture shift to more recovery-focused values and practices across organisations was more likely '*if a sufficient core is involved to help carry things forward*'. Therefore, while it was argued that '*empowering people at the coal face is really important*', there was a feeling that managers had to be targeted too.

3.147 The trainers felt that one of the strengths of the training was its flexibility. Trainers described how they had been able to adjust to respond to the needs and dynamics of the groups.

3.148 While the trainers accepted that there is always a need for some flexibility, it was felt that it would have been better if they could have had more information about the organisations and participants prior to the sessions taking place. Such insights would help tailor the training to participants' needs, in particular, support them in making changes.

3.149 Most felt that the training had tried to cover too much ground in too little time[32]. There was recognition that material from the 10 ESCs training and the Realising Recovery training – both of which were longer than two days – had been condensed into two days. Some felt that because of this, the *Recovery in Practice* training moved from one exercise to another too quickly. As a result, it was felt that participants did not understand the context for the various exercises and how their discussions contributed to the training's learning outcomes. Some felt that the programme had not built in sufficient time or opportunity for participants to reflect sufficiently on what they learned.

3.150 Some felt that the exercises on person centred planning tools were inappropriate, with one saying '*I think a little knowledge is a dangerous thing'*. This self-same point had been made by a participant. As a consequence, there were suggestions that these exercises should be dropped altogether. There was a suggestion that instead participants could simply be signposted to information on these tools. However, trainers were of the shared view that the input on WRAP should be maintained.

3.151 There was an over-riding acknowledgement that the training was a pilot, and that successive sessions had provided opportunities for the trainers to reflect on what went well and less well. As a result, the training evolved (and was believed to improve) over the sessions. Against this backdrop of improvement however, it was felt that there was nevertheless a need for any subsequent Recovery in Practice training to address the limitations outlined above.

[32] In fact, the SRN team had expressed their concern about the overly ambitious scope and content of the training programme prior to the sessions being delivered

4 Reflections and recommendations

4.1 This chapter distils key findings and considers the implications of these for any future *Recovery in Practice* training targeted at those working in the voluntary sector.

Summary of key points:

The evaluation points to strengthened attitudes to recovery among many participants.

The key issue is whether the training adds 'sufficient value.'

The chapter identifies potential improvements that could be made to the targeting, content and delivery of the training programme.

Adding value rather than simply preaching to the converted

4.2 One of the trainers highlighted an important paradox: the likelihood that the training would be most useful to those who already hold recovery values. This issue emerged in various guises throughout the evaluation with concerns being expressed that to some extent at least, the training may have been preaching to the converted.

4.3 There was some empirical support for this notion: participants' responses to the belief inventory indicated that on balance, the majority came to the training holding values that were consistent with recovery. Furthermore, participants and trainers were of the view that the person-centred principles and practices that are a common feature of voluntary sector service provision had many parallels with those for recovery.

4.4 Despite these concerns there was evidence that most participants did indeed derive some benefit from attending the training. There was evidence to indicate that the training reinforced and strengthened recovery beliefs and improved participants' (self–reported) confidence in talking about recovery and engaging in recovery practices. And although evidence of such effectiveness was quite limited in some individuals, *overall* the findings suggest that the bulk experienced some, albeit modest, strengthening of their beliefs. This testifies to the conclusion that the majority of participants were affected (positively) by the training. This is a good news story and it is important that this important finding is not overlooked.

4.5 However, while there was some evidence of the training strengthening beliefs and confidence, the question remains however about what level of change is 'worthwhile'? There are two dimensions to this:

- first, what level of change would those funding and delivering the programme feel is acceptable given the resources involved?; and

- second, are these gains valued by the participants?

4.6 In terms of the second question – are these gains valued by the participants – the findings present a complex picture. Certainly some participants, particularly those working on a face-to-face basis with clients, felt that the training had given them fresh insights. Others however, felt that the training simply reinforced what they already knew, and some of these considered such reinforcement or affirmation to be worthwhile whereas others did not.

4.7 The one belief where there was evidence of a positive shift was in attitudes to the 'workers should share aspects of their own lives to inspire hope and recovery'. As this is an issue that is considered important by service users[33] yet can often be contentious for practitioners[34], it can be considered as another mark of the programme's success.

4.8 So while there was evidence of the training having been effective, albeit to a modest degree, the question remains – *is this of a sufficient degree to justify the money and time spent on it?*

4.9 The remainder of this chapter considers how the programme might be refined in order to make it a more rewarding experience for those who attend and a better use of resources (money and time) for not only participants but also those involved in the funding and delivery of the training.

Diverse needs and targeting issues

4.10 The training was attended by individuals with diverse roles and levels of expertise. At one end of the spectrum were individuals who worked at the coal face, some of whom were less familiar with mental health issues and terminology either because they worked in services that provided support and care for a broad spectrum of people and/or the nature of the support that they provided was quite holistic. At the other end of the spectrum were individuals, including managers, who had worked in mental health services for a long time.

4.11 This diversity was associated with some difficulties for both participants and the trainers. From the participants' side, the diversity – while interesting – was also a source of some frustration, particularly in group discussions. Furthermore, some felt that the training was not pitched at the right level for them.

4.12 The diverse range of participants also posed challenges for the trainers. While there was a view that 'there was something for everyone', there was an acknowledgement that it is difficult to deliver training to a highly heterogeneous mix of people who have assorted needs and expectations.

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[33] Schinkel M and Dorrer N (2007) Towards Recovery Competencies in Scotland: The Views of Key Stakeholder Groups Edinburgh Scottish Executive.

[34] Devlin Beattie Partnership Scottish Association for Mental Health (SAMH): Evaluation of Recovery Approach Report. August 2007

Such problems were compounded by the fact that trainers did not have information in advance of the sessions about who would be attending, their level of knowledge and expertise in recovery, and their expectations of recovery.

4.13 In view of the limitations of a 'one size fits all' approach, it is recommended that any future training clearly specifies its target group and tailors the training to meet their particular needs. As such, it is recommended that the target group for *Recovery in Practice* is narrowed to those working on a face-to face basis with their clients. Furthermore, it would be useful to collect some basic information prior to the training profiling individuals' roles and those of their organisations, their knowledge and beliefs about recovery, and about what they hope to achieve from attending. In turn, this information should be shared with the trainers (in advance of their delivery of the training programme) so that they tailor the training accordingly.

Meeting the needs of front-line workers

4.14 This evaluation suggested that in its current form, the training was considered to be more appropriate to front line workers i.e. those working directly with their clients. This is unsurprising given that a significant portion of the training involved exercises and discussion on how to support individuals' recovery.

4.15 Participants valued hearing service users' personal stories and it will be important to preserve this important dimension of the training. However, at times participants failed to understand the relevance of these accounts. Any future training should ensure that the implications of these personal accounts are clearly stated and explicitly aligned with the intended learning outcome.

4.16 The trainers were praised for making the training interesting, accessible, safe and energetic. Such qualities are important for ensuring that participants do not feel threatened, judged or criticised and are enthused in taking forward recovery practices. Thus any future training needs to recognise and value the important contribution of such 'soft' factors.

4.17 Future training to front-line workers also needs to address limitations identified in the pilot.

4.18 Thus future training should comprise a shorter and more focused programme that builds in more time for reflection, and which aligns the insights gained with the learning outcomes in order that participants better understand the take home messages.

4.19 There needs to be acknowledgement that not all participants work in mental health. Therefore if discussions stray into very specific mental health issues that may be unfamiliar to those working in other/more generic services, trainers should step in as appropriate e.g. by explaining the points being made, or by refocusing the discussions on issues which are relevant to all.

4.20 The experiential elements of the training should use a facilitator. As such the facilitator's role should not simply be one of keeping participants 'to task' but should ensure that that no-one leaves the discussions with a misunderstanding of the issues. It may be that the trainers themselves are the people best placed then to act as moderators in view of their recovery expertise and their understanding of how the exercises are intended to contribute to the training's intended learning outcomes. However, as it will be important to ensure that participants continue to be split into groups that are small enough to engender participation of all those involved, and as it may prove too demanding for trainers to facilitate group discussions while at the same time managing the training as a whole (including seeing to the inevitable practical issues that emerge on the day), additional group facilitators should be enlisted. Such facilitators will need to have a firm grasp of recovery principles and be thoroughly briefed in order that they understand the intended learning outcomes of each group work exercise.

4.21 A small number of participants indicated that exercises requiring them to reflect on their personal feelings and then share these with the group left them feeling upset. More thought needs to be put into these. At the very least, prior to engaging in these, participants should be told that they will be asked to share their personal experiences with the group. One participant talked of devising fictitious rather than disclosing real experiences. Trainers should consider whether this is an option that they want to suggest to participants. Another option, suggested by a trainer, was that participants share their professional (rather than personal) experiences in these exercises.

4.22 This evaluation highlighted participants' difficulties in understanding how recovery principles and practices are 'different' to the person-centred ones that are a common feature in the voluntary sector. In fact, failing to understand the distinction led to many participants feeling that the training had not offered them anything new and that recovery is simply a new 'buzz word'. Furthermore, one interviewee who tried to take encourage more discussion on recovery within his/her organisation faced something of a brick wall as his/her managers failed to understand how embracing recovery as a guiding principle would offer the organisation anything 'new'. For these reasons, it is recommended that future training and associated promotional materials tease out, and give more prominence to, the key recovery themes that are additional to (and complement) person centred approaches so that these don't get lost in the mix.

4.23 The use of person-centred planning tools has been highlighted as a cornerstone of recovery practice[35]. So it was understandable that the training attempted to give participants some experience of using these. However, in view of concerns that a little knowledge can be dangerous, the exercises on using person centred tools need far more thought. While some interviewees and trainers felt that these exercises should be dropped from the programme

[35] Realising Recovery: a national framework for learning and training in recovery focused practice. NHS Education for Scotland and Scottish Recovery Network 2007.

altogether, doing so runs the risk of sidetracking a significant strand to recovery focused practice. Instead, it might be useful to simply make participants aware of the suite of options available and signpost them to sources of additional information on these.

4.24 There was an enormous amount of interest in WRAP with many participants saying that they would like to hear more about this. More consideration then has to be given to what this input is intending to achieve and provide a level of information that is likely to be useful and satisfying. As a minimum, participants should be given information on how training might be accessed, and how this might best be taken forward in their organisations.

Supporting and mainstreaming recovery in organisations

4.25 It is generally well accepted that training by itself is unlikely to lead to changed practices, and this point has been made in relation to recovery specifically in Realising Recovery: a national framework for learning and training in recovery focused practice:

4.26 'In order for workers to put their learning into practice, there is a need for services to give consideration as to how recovery focused practice may be implemented within teams and across services.'[36.]

4.27 In this evaluation, a number of factors were felt to be important in terms of organisations' likelihood to embrace recovery principles and practices. One of these was the view that organisational change was more likely if the 'right' people are involved, and in sufficient numbers.

4.28 Therefore, it would seem that the approach taken by SRN in allocating up to eight training places per organisation was sound in terms of trying to develop a 'critical mass' of recovery champions within the host organisations. It is recommended that future training seeks to bring together many people from within one organisation.

4.29 In the long term, an expedient way to achieve this may be through the development of a trainer for trainers' course. This would of course require, first developing a good 'product' (a core training programme that addresses the limitations identified by this evaluation) and finding out what support trainers/learning managers would need to roll this out.

4.30 However targeting significant numbers of frontline workers in a given organisation and delivering an effective training programme may not be sufficient in itself. Changes in practice will be more likely to happen (and to be sustained) if there are appropriate and adequate supervision and support

[36] Realising Recovery: a national framework for learning and training in recovery focused practice. NHS Education for Scotland and Scottish Recovery Network 2007.

structures[37.] In recognition of this, applications for places on the Recovery in Practice training had to be completed by individuals with responsibility for staff training and development within participants' organisations. However, on the basis of the six follow up interviews in this evaluation, there was no sense either of any organisational expectation that these workers would do anything differently after attending the training, or indeed that by allowing the participant to attend, that the organisation had, in a sense, committed to nurture and support participants in applying recovery principles to their work. For these reasons, it might be advisable that in any future training, the application process requires approval from line managers.

4.31 It is important to acknowledge however that changes (or reinforcement) in coal-face workers' values and practices will (at best) be felt by the individuals who they support, and it is unlikely that these workers will be able to create a culture change across the whole organisation. In recognition of this, the current training was open to managers and others who could cascade learning through their organisation. Yet the training was not specifically developed to meet their needs: it focused on how workers can support individuals' recovery rather than addressing how they might engender organisation-wide changes, an altogether more ambitious outcome. Thus there remains an outstanding need for voluntary organisations to consider how they might embed recovery values and practices across the organisation.

4.32 If the resources were available, it might be useful for SRN to explore whether there is an appetite among managers in voluntary organisations to reflect on ways to mainstream recovery across their organisations, and if so, to address this in ways that meet their preferred learning styles e.g. through training, learning sets, signposting to online resources etc.

4.33 The bottom line is that changes in practice have to be cultivated and supported, and this requires the buy-in and commitment of not just those working on a daily basis with their clients, but from managers – both middle managers and those at the most senior levels. This has implications not only for what training is provided and who should attend, but for what happens after the training.

4.34 The significant investment that organisations make by releasing staff to attend two days' training might be better used if these organisations put in place 'follow through' systems e.g. to obtain employees' feedback on the training and to consider whether and how they can help staff build on what they have learned.

[37] Schinkel M and Dorrer N (2007) Towards Recovery Competencies in Scotland: The Views of Key Stakeholder Groups Edinburgh Scottish Executive.

The belief inventory

4.35 The pre- and post-training questionnaires included a scale that attempted to assess the extent to which participants had attitudes that were consistent with recovery principles. In this report, this scale is called the ‘belief inventory’.

4.36 It is important to acknowledge and reiterate limitations of this scale. These include the fact that it was developed for this evaluation, and as such, was not piloted. One of the casualties of this was that one item quite simply ‘did not work’ i.e. ‘mental health workers should think of things for service users to aim for’.

4.37 In an ideal world, measurement tools are ‘validated’. This is a process, to test out whether scales actually measure what they intend to. However, such validation is a long process, and was not feasible within the context of this evaluation.

4.38 Despite the fact that the inventory was not formally validated, the items were based on the principles enshrined in recovery frameworks and recommendations (as described earlier in the report) and were based on the learning outcomes of the training materials on which Recovery in Practice were based. Thus, the items had a strong theoretical basis.

4.39 A common problem with 5-point Likert scales (as used in the belief inventory) is central tendency bias i.e. a tendency for participants to opt for the mid-point of the scale. It is encouraging that this tendency was not evident in participants’ responses: with the exception of one item, the majority of ratings were clustered to indicate general agreement or general disagreement, and the number of participants indicating ‘neither agree nor disagree’ was consistently low.

4.40 Furthermore, and reassuringly, the responses to the belief inventory suggest that in general terms, it achieved what it set out to: it identified changes in beliefs, and these changes were consistent with the intended outcomes of the training i.e. overall they suggested that the training had reinforced recovery values and beliefs.

4.41 The fact that the inventory picked up on changes in the absence of participants being able to see their pre-training responses would seem to add credence to the conclusion that the tool was a useful and, to some extent at least, sensitive gauge of beliefs.

4.42 The one items that generated a large number of ‘neither agree nor disagree’ responses was ‘mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients’. This was perhaps to be expected: previous research had indicated that this was a notion with which many practitioners struggle[38] and of all the statements it was considered

[38] Devlin Beattie Partnership Scottish Association for Mental Health (SAMH): Evaluation of Recovery Approach Report. August 2007

to be the one most likely to be viewed as contentious[39]. The fact that following the training, the distribution of responses shifted in the expected direction (with the majority of participants agreeing with the statement) would seem to support the conclusion that this item too had some validity.

4.43 Overall the belief inventory seemed to serve its purpose. Therefore, because it seemed to have some utility, it is suggested that the belief inventory developed for this evaluation might be utilised in the future e.g. to gauge prospective participants' views before training in order that the content can be pitched at an appropriate level. However, in view of the reflections above, if decisions are taken to use the tool again, it is recommended that each of the items is revisited and reworded (or removed) as appropriate.

Concluding comments

4.44 It is important to remember that this was a pilot training programme and as such was set up to 'try out' a package developed for the voluntary sector. This evaluation has highlighted some key strengths in this programme and its delivery. Strikingly, the evaluation has revealed that the training was effective in strengthening values and beliefs. The key issue is whether it achieved this on a large enough scale i.e. did it benefit enough of the participants and did it benefit them 'enough'?

4.45 The evaluation has also uncovered weaknesses. It is important to view these from a position of learning, in particular, reflecting on how future training might be improved.

4.46 Ultimately, the purpose of the training was to play a part in strengthening recovery values and practices in voluntary sector organisations. There are two important implications of this. First, a two day training programme for frontline workers cannot be expected in itself to change practices in a sustained manner. Second, recovery practices will be more likely to flourish in those organisations which nurture and support these.

4.47 It is important that there are appropriate expectations therefore of what a training programme might realistically achieve with its participants, in particular just how far it can take participants within the context of a short programme before it passes the baton back to the host organisation.

[39] Personal communication with Simon Bradstreet, Director, SRN

Appendices:

Details on administration of questionnaires

Data tables 1 -10

Details on administration of questionnaires

Procedures were put in place to enable:

- questionnaires to be completed on an anonymous basis; and
- to match each individual's pre-training and post-training questionnaires.

These procedures are detailed below.

Administration of pre-training questionnaires

SRN assigned each (blank) questionnaire with a unique code, and generated a master list that linked these codes with the name of the participant. The researcher was given a list of these codes but not the names (and therefore could not link questionnaire codes with individuals).

SRN posted out questionnaires to all prospective participants SRN prior to the training. These were accompanied by an information sheet describing the evaluation and a pre-paid envelope addressed to the researcher.

Questionnaires were completed on an anonymous basis. However, to allow the researcher to match each individual's pre-training questionnaire with the one they would complete after the training, respondents were asked to provide their date of birth and their mother's maiden name.

Completed questionnaires were posted directly to the researcher. As the researcher had a list of all those codes she should expect to receive, she contacted SRN a regular intervals to update them on which were outstanding. In turn, SRN referred to the master list and issued a reminder to the individuals involved.

Administration of post--training questionnaires

The post-training questionnaires were given to participants the end of the training and were completed on an anonymous basis. As before, respondents were asked to provide their date of birth and mother's maiden name.

Each participant was given a blank envelope for his/her completed questionnaire. These were collated by the trainer (still in their sealed envelopes) and sent to the researcher.

Analysis of questionnaires

The researcher 'paired' pre- and post-training questionnaires on the basis of information on the session that was attended, participant date of birth and mother's maiden name. In this way, she was able to match each individual's pre- and post-training questionnaire.

Table one: Breakdown of pre-training responses by recovery belief

Shaded areas represent most common response

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
There is no right or wrong way to recover	33	32	3	1	0
Mental health workers should try to solve as many problems as possible for their clients	1	3	14	43	8
Mental health workers should think of things for service users to aim for	2	16	27	20	4
Recovery is relevant to anyone with a mental health problem	31	30	6	2	0
Mental health workers need to be able to step back at times to allow people to take control for managing their own recovery and wellness	44	23	1	0	1
Workers should discourage people with mental health problems from talking about being sad	2	2	4	32	29
It is important to maximise opportunities for all mental health service users, including those subject to compulsory powers, to make choices about how they live	44	23	2	0	0
Mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients	6	22	26	12	3
I have a pretty good idea what individuals need to help them recover even before I meet them	0	1	7	24	37
At all times, mental health workers must minimise the risks that their clients face	4	10	19	30	6
Mental health workers should identify goals for their clients	1	9	19	30	10
It is important to let some people know that they will never recover	1	3	12	23	30

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
Individuals' diagnosis and symptoms are more important in planning recovery than their strengths and aspirations	2	0	5	33	29
There are key things that all individuals can do to help their recovery	23	39	5	2	0
Risk assessment is the responsibility of the mental health worker and not their clients	3	9	9	36	12
The role of the mental health worker is to address symptoms rather than to understand their clients	1	1	2	27	38
Working with service users provide opportunities for mental health workers to learn about themselves	11	32	19	3	4
I feel that it's important that mental health workers reflect on their own and others' practice to examine whether hopeful messages are being conveyed	28	37	4	0	0
Mental health workers can only support an individual's recovery if they understand what's important to him/her	23	32	8	3	3
Asking someone if they are feeling suicidal increases the risk of the individual trying to kill himself/herself	0	0	6	25	38
I am aware of a number of person centred tools that can be used to support clients in setting their goals	6	45	11	7	0
I feel that person centred tools/approaches *are useful* for helping clients in their own recovery	15	47	7	0	0
It is the role of the mental health worker to tell clients what they need to do to recover	0	2	10	38	19

Table two: Self-reported confidence* pre-training

Shaded areas represent most common response

Level of confidence on scale 1 – 6 where 1 = extremely unconfident and 6 = extremely confident	1	2	3	4	5	6
Working from a recovery based philosophy	5	12	19	16	14	3
Undertaking a recovery based assessment	9	17	25	6	9	3
Using person centred tools/approaches with clients	6	7	8	22	17	9
Developing a recovery based plan with a client	7	9	17	16	15	5
Working with a challenging situation from a recovery based perspective	9	13	19	14	11	3
Providing an overview of recovery principles to a group of colleagues	9	17	22	8	10	3

*** Self-reported level of confidence based on scale 1 – 6, where 1 = extremely unconfident and 6 = extremely confident**

Table three: Breakdown of post-training responses by recovery belief (NB items marked with an asterisk * were not completed by all and so do not add up to 69). Shaded areas represent most common response and numbers in bold represent those items for which there has been a positive shift in the most common response

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
There is no right or wrong way to recover	55	10	2	1	1
Mental health workers should try to solve as many problems as possible for their clients	0	1	10	30	28
* Mental health workers should think of things for service users to aim for	5	7	24	19	12
Recovery is relevant to anyone with a mental health problem	46	11	6	4	2
Mental health workers need to be able to step back at times to allow people to take control for managing their own recovery and wellness	56	12	0	1	0
Workers should discourage people with mental health problems from talking about being sad	2	1	2	21	**43**
It is important to maximise opportunities for all mental health service users, including those subject to compulsory powers, to make choices about how they live	59	10	0	0	0
Mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients	11	**35**	18	3	2
I have a pretty good idea what individuals need to help them recover even before I meet them	0	3	5	18	43
At all times, mental health workers must minimise the risks that their clients face	7	3	12	34	13
Mental health workers should identify goals for their clients	2	5	13	28	21
It is important to let some people know that they will never recover	2	2	3	11	51

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
* Individuals' diagnosis and symptoms are more important in planning recovery than their strengths and aspirations	0	1	6	17	**44**
* There are key things that all individuals can do to help their recovery	**38**	27	2	1	0
* Risk assessment is the responsibility of the mental health worker and not their clients	1	3	13	35	16
* The role of the mental health worker is to address symptoms rather than to understand their clients	0	0	2	22	44
* Working with service users provide opportunities for mental health workers to learn about themselves	24	25	14	5	0
* I feel that it's important that mental health workers reflect on their own and others' practice to examine whether hopeful messages are being conveyed	**43**	20	5	0	0
* Mental health workers can only support an individual's recovery if they understand what's important to him/her	**38**	24	5	1	0
** Asking someone if they are feeling suicidal increases the risk of the individual trying to kill himself/herself*	1	3	5	18	41
** I am aware of a number of person centred tools that can be used to support clients in setting their goals*	31	34	3	0	0
* I feel that person centred tools/approaches *are useful* for helping clients in their own recovery	**42**	24	2	0	0
*It is the role of the mental health worker to tell clients what they need to do to recover	0	2	7	17	**42**

Table four: Number of individuals demonstrating a change per recovery belief

	No with positive change	No with negative change	Net change i.e. no in column 1 minus no in column 2
There is no right or wrong way to recover	26	5	21
Mental health workers should try to solve as many problems as possible for their clients	28	5	23
Mental health workers should think of things for service users to aim for	28	11	17
Recovery is relevant to anyone with a mental health problem	24	13	11
Mental health workers need to be able to step back at times to allow people to take control for managing their own recovery and wellness	15	4	11
Workers should discourage people with mental health problems from talking about being sad	23	8	15
It is important to maximise opportunities for all mental health service users, including those subject to compulsory powers, to make choices about how they live	17	1	16
Mental health workers should be willing to share aspects of their own lives to inspire hope and recovery in their clients	36	10	26
I have a pretty good idea what individuals need to help them recover even before I meet them	15	11	4
At all times, mental health workers must minimise the risks that their clients face	28	15	13
Mental health workers should identify goals for their clients	29	5	24
It is important to let some people know that they will never recover	29	8	21

	No with positive change	No with negative change	
Individuals' diagnosis and symptoms are more important in planning recovery than their strengths and aspirations	21	7	14
There are key things that all individuals can do to help their recovery	26	10	16
Risk assessment is the responsibility of the mental health worker and not their clients	23	9	16
The role of the mental health worker is to address symptoms rather than to understand their clients	15	5	10
Working with service users provide opportunities for mental health workers to learn about themselves	32	9	23
I feel that it's important that mental health workers reflect on their own and others' practice to examine whether hopeful messages are being conveyed	21	7	14
Mental health workers can only support an individual's recovery if they understand what's important to him/her	25	6	19
Asking someone if they are feeling suicidal increases the risk of the individual trying to kill himself/herself	11	9	2
I am aware of a number of person centred tools that can be used to support clients in setting their goals	38	2	36
I feel that person centred tools/approaches *are useful* for helping clients in their own recovery	32	4	28
It is the role of the mental health worker to tell clients what they need to do to recover	30	7	23

Table five: Number of strengthened recovery beliefs by number of participants

NB: the figures below exclude knowledge item: 'I am aware of a number of person centred tools that can be used to support clients in setting their goals'

No of items with +ve change	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
No of participants	2	4	4	3	10	11	3	4	9	7	4	4	1	2	0	0	0	1

Table six: Number of strengthened recovery beliefs minus number of weakened recovery beliefs by number of participants NB: the figures below exclude knowledge item: 'I am aware of a number of person centred tools that can be used to support clients in setting their goals'

No of items with +ve change minus no with –ve change	-7	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
No of participants	1	0	0	1	0	2	3	3	5	5	6	6	5	5	8	3	7	1	2	3	0	2	0	0	0	1

Table seven: Self-reported confidence* post-training

Shaded areas represent most common response and numbers in bold represent those items for which there has been a positive shift in the most common response

Level of confidence on scale 1 – 6 where 1 = extremely unconfident and 6 = extremely confident	1	2	3	4	5	6
Working from a recovery based philosophy	1	2	3	21	**29**	13
Undertaking a recovery based assessment	1	2	10	**28**	22	6
Using person centred tools/approaches with clients	1	0	6	15	**35**	12
Developing a recovery based plan with a client	1	2	10	16	**31**	9
Working with a challenging situation from a recovery based perspective	1	0	13	**24**	22	9
Providing an overview of recovery principles to a group of colleagues	1	1	7	21	**29**	10

*** Self-reported level of confidence based on scale 1 – 6, where 1 = extremely unconfident and 6 = extremely confident**

Table eight: No of participants indicating confidence change across each item

	No change in confidence	No with increased confidence	No with decreased confidence
Working from a recovery based philosophy	21	47	1
Undertaking a recovery based assessment	13	51	5
Using person centred tools/approaches with clients	23	40	6
Developing a recovery based plan with a client	19	45	5
Working with a challenging situation from a recovery based perspective	14	51	4
Providing an overview of recovery principles to a group of colleagues	16	50	3

Table nine: No of items on which self-reported confidence changes

No of items with improved confidence	No of participants
0	2
1	2
2	7
3	4
4	7
5	12
6	27

Table ten: Potential role in influencing broader organisational values and practices.

NB: Some did not complete this table at all or missed items

	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
I intend to share what I have learned with others in my organisation	46	16	2	0	0
My organisation has appropriate support in place to allow me to apply what I have learned on the training	28	30	6	0	0
I feel that I can influence the recovery values of my organisation	14	37	11	2	0
There is a commitment to recovery among the senior managers of my organisation	29	26	6	2	0