



**NHS Education for Scotland / Scottish Recovery Network – Mental Health Recovery
Project**

**A Literature Review and Documentary Analysis on Recovery Training in Mental
Health Practice**

March 2007



Scottish Recovery Network

AskClyde

MORE THAN RESEARCH AND CONSULTANCY

Acknowledgements

AskClyde was commissioned by NHS Education for Scotland to undertake a literature search and documentary analysis on recovery training in mental health practice. This report outlines the work undertaken and findings.

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Language used in the writing of this report

Throughout the literature reviewed there were different terms used to refer to people who have used or are currently using mental health services. These included the terms 'consumer', 'patient', 'client', 'user' and 'service user'. For the ease of the reader, the term 'service user' has been used throughout the report.

Individuals who were undertaking the training have been referred to as 'participants' and individuals running the training have been referred to as 'trainers'. Training or Workshops undertaken are referred to as 'Training'.

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1.0 Introduction & Background to the study

The NES/SRN Mental Health Recovery Project is a joint project between NHS Education for Scotland and the Scottish Recovery Network. The project is part of the overall implementation of the actions contained in *Rights, Relationships and Recovery* (Scottish Executive, 2006), the national review of mental health nursing in Scotland. The overall aim of the project is to provide an outline framework for training/education for mental health nurses in relation to recovery and identify next actions for the implementation of this framework. The framework will identify the skills, knowledge and values required for mental health nurses to work in a recovery focused way with mental health service users and their carers, families or friends. It will encompass both student nurses and qualified staff and will take account of other educational frameworks and relevant statutory requirements. The underlying principles of the project are to undertake all work in accordance to the values adopted in *Rights, Relationships and Recovery* and the Scottish Recovery Network's commitment to the lived experiences of service users being central to all activity.

AskClyde was commissioned to undertake a literature review and documentary analysis to identify and analyse UK and international literature on recovery training in mental health practice.

2.0 Aims and Objectives of this study

2.1 Aims of the study

To undertake a literature review and documentary analysis to identify and analyse UK and international literature on recovery training in mental health practice.

2.2 Objectives

- Undertake a literature search of electronic databases from nursing, allied health professions, psychological, social care and medical disciplines using a number of search terms on recovery training in mental health practice.
- Undertake internet research of grey literature / unpublished studies, including training course programmes, accompanying materials and evaluation reports.
- To undertake personal communication with relevant projects in order to gather any further grey literature or unpublished studies in line with the research aims.
- To design a documentary analysis framework in line with specific criteria, as outlined in the Methods section of the Research Proposal.
- To undertake documentary analysis using the designed documentary analysis framework.
- To provide a full report in line with the research aims and objectives.

3.0 Methods

3.1 Literature Search

A literature search of relevant articles was undertaken using a number of key electronic databases from the following disciplines: nursing (BNI & CINAHL), allied health professions (AMED), psychological (PSYCHINFO), social care (ASSIA) and medical (MEDLINE). Search terms ("mental health" "recovery" "nursing" "worker" "psychiatric" "training" "education" "recovery based approaches" "evaluation") and combinations of these relevant search terms were utilized in order to form a comprehensive search. All articles relevant to the search were chosen for documentary analysis. Access to electronic databases and journals was through the NHS Education for Scotland eLibrary and other electronic sources.

Internet research of grey literature / unpublished studies was undertaken, including training course programmes, accompanying materials and evaluation reports. Personal communication with relevant projects was undertaken in order to gather any further grey literature / unpublished studies in line with the research aim. These personal communications were selected from UK and international links which AskClyde staff have formed. This includes an international mental health nursing study tour undertaken in 2005 of mental health recovery services / projects.

3.2 Documentary Analysis

A documentary analysis framework was designed in order to analyse the literature identified on recovery training in mental health practice. This framework was used to develop a guide to analyse individual documents focusing on the following analysis criteria:

- Training/educational methodology
- Preparation of trainers
- Delivery – who, where, when
- Key Content
- Examples of national roll-out
- Impact on practice
- Accreditation issues

Questions were developed for each component of the analysis framework to ensure that all areas of recovery training in mental health practice were addressed in line with the analysis criteria. The framework provided a clear structure of the analysis for all involved and maintained consistency of analysis across the AskClyde team.

A meeting was held mid-project in order to discuss emerging findings and to further refine the parameters of the analysis.

4.0 Findings – literature search

4.1 Literature search using Electronic Databases

Six electronic databases were searched using the specified search terms and combinations of them. The titles and abstracts of all articles selected were then read and only the relevant articles were selected for printing. Articles were printed from electronic journals via the NHS Education for Scotland eLibrary.

Not all articles were found in these two electronic resources. Those obtainable were printed forming a hard copy. The documents selected for printing were kept very broad, once read; only those relevant to recovery training and education for mental health professionals were selected. The following indicates the number of articles selected from each database and which were successfully obtained, electronically.

PsychINFO (2000 - 2007)

25 relevant articles – 16 obtained electronically.

CINAHL (2000 – 2007)

17 relevant articles – 7 obtained electronically.

British Nursing Index (2000 – 2006)

13 relevant articles – 7 obtained electronically.

MEDLINE (2000 – 2007)

7 relevant articles – 5 obtained electronically.

AMED (2000 – 2006)

6 relevant articles – 5 obtained electronically.

ASSIA (2007 – 2007)

4 relevant articles – 2 obtained electronically.

It was hoped, the search of ASSIA would result in some interesting articles from OpenMind (MIND mental health magazine) directed towards service user views/opinions on developing training in recovery. Using the search terms selected, no articles on training or education in recovery were identified.

4.2 Search of grey literature using Internet Research

Due to the broad subject matter it was difficult to locate specific articles. However, the following websites have provided some relevant information:

Kings College London, Community Mental Health

<http://www.iop.kcl.ac.uk/departments/?locator=342>

National Institute of Mental Health in England (NIMHE)

<http://kc.nimhe.org.uk/upload/Best%20Practices%20in%20MH%20Recovery%20Poster.pdf>

The National centre of mental health research and workforce development (New Zealand)

www.tepou.co.nz

Working to Recovery – Ron Coleman & Karen Taylor (Scotland)

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

Meta Services (USA)

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

4.3 Search of grey literature using Personal Communications

Personal communications were made throughout the national and international mental health communities. Table 1 provides details of countries contacted. Information was gathered via email, with an attached electronic letter (see Appendix 1). Although, it was the summer holidays for many practitioners in Australia and New Zealand, there was good response with many practitioners having a keen interest in the work being undertaken. A number of training handbooks and evaluations were sent which have been valuable for the documentary analysis.

Table 1: Number of Emails sent to search the grey area

COUNTRY	NUMBER OF EMAILS
England	25
New Zealand	22
USA	17
Australia	15
Ireland	7
Scotland	6
Canada	2
Germany	2
Sweden	1
Turkey	1
TOTAL	98

5.0 Findings – content analysis

There are a number of different documents included within this analysis, including:

- Journal Articles
- Emails
- PowerPoint presentations
- Handbooks of courses
- Minutes from meetings
- Training plans
- Evaluation reports

Little information was found on undergraduate recovery education.

Due to tight deadlines, only a limited amount of information could be collected and read within the specified timeframes. However, by the end of the period of documentary analysis, information saturation had been reached, with no more new topics/areas being found.

In total 30 training/educational courses were analysed, ranging across New Zealand (10), United Kingdom (9), Australia (7) and United States of America (4). Appendix 2, illustrates the specific organisation, location and reference.

5.1 Training / Educational Methodology

The majority of the documents outlined training for participants working in or using mental health services. However, a few highlighted training of undergraduate students in recovery (9, 2, 49).

OVERALL PURPOSE

From the documents analysed, the overall purpose of the training had an affect upon the training / educational methodology used. Each training/educational programme analysed had slightly different purpose and so different methodologies. Some examples of the overall purpose are listed below:

- For participants to take ownership of the training and therefore their recovery practice (1).
- Enhance participants understanding of recovery, so to promote and support self directed recovery, facilitating the move towards recovery-orientated practice (2).
- To enhance knowledge base and undertake professional development on a mentally well workplace and recovery (4).
- How to implement recovery in a clinical area (for management) (15).
- Honour existing knowledge, skills and experience, but reflect on how to integrate new knowledge and skills into a recovery paradigm (1).
- Develop a shared understanding of recovery (7).
- Increase confidence of recovery practices and skills in developing recovery orientated services (11).
- To raise recovery awareness in mental health services (27).

METHODS

There were many different styles used in designing the training programmes. The most common tool was self reflection of participant's experiences and practices, to identify how areas could be changed (1, 2, 3, 9, 7, 11, 27, 35) and many documents identified the importance of this process. This experiential approach involved participants looking

at their own recovery and life journey, drawing on personal life experiences, being guided to identify what recovery meant to them individually and to understand recovery as a unique process. (1, 2, 7, 9, 11). Role-plays allowed participants to 'step into the shoes of others' allowing the individual to see situations from a different perspective (1). A number of documents took this further to reflect on practitioners practice and recovery practices (2, 7, 11).

Training formats used a variety of different tools, as listed below:

- PowerPoint (5, 6, 7, 8, 9, 11, 12, 17, 18, 21, 26, 36, 39, 47, 48, 49).
- Role Plays (1, 3, 9, 11, 36, 39).
- Handouts (5, 6, 7, 8).
- DVD / Video Presentation (5, 6, 7, 36).
- Fun exercises & Ice Breakers (5, 6, 8).
- Discussion in pairs & groups (5, 6, 9, 36).
- Hear service user stories (7, 9).
- Workbook (8, 13).
- Reflection & Challenge (2, 3, 12).
- Class Activities (9).
- Website (10).
- Library (10).
- Self help materials (1).
- Group Work (7).
- Brainstorming (39).
- E-Learning (39).

One document identified the importance of one topic/module needing to support the next, providing cumulative learning and not independent topics/modules (2).

The use of Recovery Conferences was also an important area of recovery training and education. Conferences provide an opportunity for service users to share their stories, good recovery practices to be identified, networking and an opportunity for interprofessional, service user and carer learning (21, 34).

5.2 Preparation of trainers

NUMBER & 'TYPE' OF TRAINERS

The number of trainers varied across the different trainings, which generally followed the logic that the longer the training the more the number of trainers. One evaluation stated the importance of the use of 2 trainers because it was too much to expect one person to facilitate the whole training alone (2).

- 3 Trainers (4 consecutive days training) (5, 6).
- 2 Trainers (1/2 day training) (5, 6).
- 2 Trainers (2).
- 1 Trainer (4 consecutive days) (4).

Two documents identified the importance of using a trainer who was independent from the mental health service, (4, 27).

Much of the literature identified the importance of using service users and mental health workers, to provide training together (2, 4, 15, 34, 37, 52), although the importance of the service user not being "stuck" was noted (2). The use of 'Recovery Champions' (15), could be one way of getting round this, or inviting service users or family members as guest trainers (9); and/or use of a video/audiotapes of service users reflecting on their experiences (16, 38), or if nothing else articles of stories (10, 38). The importance of service user's stories was seen as key for developing recovery practices as it allows for the formation of dialogues between service users and mental health workers (10, 34, 38).

PREPARATION OF TRAINERS

A number of training handbooks provided examples on how to prepare trainers (4, 9), either in the form of reading materials, discussion notes, stories, lesson plans, guidelines for inviting service users and family members as guest trainers and teaching notes (8, 9), the provision of a two hour introductory session (4), or training for trainers (5, 6).

From the documents it appeared important to have trainers who had an expertise in the philosophy, principles and practices of recovery, being able to support and promote individual's self directed recovery (2, 25). The importance of trainers working and training within a recovery format was also seen as important. For example, reinforcing positive practices (2), not focusing on negatives and looking on how to change cultures.

WHO WERE THE TRAINERS

Out of the 30 training/educational courses analysed, the trainers were part of five different organisational groups. The largest amount of training/educational courses were from health boards (13 courses), with the 2nd biggest group from independent organisations (7 courses). The remaining three organisational groups were government funded (4 courses), educational institutes (2 courses) and voluntary/non-government organisations (4 courses). Appendix 3 provides a breakdown of these organisational groups in relation to country (with references indicated).

The majority of Australian trainers were part of the health board, in New Zealand and UK there was a clear distinction between trainers either being part of health boards or independent organisations.

5.3 Delivery – who, where, when

DURATION

The range of workshops/training days specified within documents outlining specific training courses spanned from a half day to six days (1, 2, 3, 4, 5, 6, 7, 8). Each training was of a different length, half day (5, 6), one day (7), two day (8), 3 day (1), five day (3) and six day (4) (one document did not provide this information (2)).

Some of the training consisted of consecutive days and others were over a longer period.

- 3 x 1 day training (once a month) – followed by 4 x ½ day workshops (within 3 month period) (1).
- 1 x 5 day training (over 5 days) – followed by 1 x 1 day workshop (3 months later) (3).
- 2 x 1 day training (once a month) – followed by: 1 x 4 day workshop (consecutive days).
1 x day training for Managers only – prior to start of the rest of the training (4).
- 1 x ½ training - then 1 x 1 day training – followed by 1 x 4 day training (over 8 day period).
1 x 1 day training for Managers only – prior to the 1 x 4 day training (5, 6).
- 12 x 2½ hour training – followed by 6 x 4 hour training (39).
- 1 x 1½ hour training (27).

One document (2) stated it was not important if the days were consecutive or not, however, if the days were spaced out, they needed to be no more than two weeks apart, for learning to be effective. Other documents stated that because the training was intense it was crucial that there was space between them. The evaluation of the 5 day residential training (3) stated it would have been better in “chunks”, over a longer period. Similarly, two different training programmes indicated it was important to ensure there were enough breaks during each day, as it was intense, especially for service users

and carers (1, 3). The importance of follow up training was also noted as important, to ensure concepts are embedded into practice (2).

One training of 4 days was delivered over an 8 day period, as it was easier to release staff and yet provide staff with the intensity of the course which was important to allow staff skills and knowledge to develop and learn how to work with various recovery tools (5, 6).

WHO FOR

Most training provided for interprofessional learning including nurses, allied health professionals, psychologists, psychotherapists, social workers, psychiatrists, service users and carers (1, 2, 3, 4, 5, 6, 7, 34, 39,) and some training was across service types in the statutory and voluntary sectors (5, 6). Only one evaluation suggested the importance of providing training without service users and carers, as it provided an environment where staff would find it easier to speak out (27). The importance of interprofessional learning was emphasised as it allowed all participants to join together as learners, with a shared investment in understanding recovery (34). Only one training was offered to just one discipline group, although additional training was offered with mixed staff interprofessionally, carers and service users (7). One document identified learning in an interprofessional environment was helpful for practitioners to learn to work with their colleagues (2).

It was noted, that there was a need for more medical representation (e.g. psychiatrist) as they hold a key position in mental health services and so their involvement to promote recovery based practice was crucial (1, 4, 40). Social work education/training was described as similar to a recovery framework, focusing on values, dignity and strengths of the individual (41).

Some training was for management staff only (5, 6). An evaluation of one training concluded that there was a need to provide training for management to ensure more successful implementation of the recovery approach in their organisation (3).

HOW MANY

- 12 service providers, 8 service users and carers (total of 6 day training) (3).
- 12 participants (total of 4 day training) (5, 6).
- 40 participants (1x2 day training) (5, 6).
- 20 participants (1 day training) (3).
- 10-15 participants (maximum 20) (2).

There was no clear indication why groups varied in size, although, there seemed to be some correlation between the length of training and size of group (the longer the training, the smaller the group), although this was not stated in any of the documents.

VOLUNTARY or MANDATORY

It was not clear in most of the documents if training was voluntary or mandatory. A number of the documents stated the training was across the whole service (1, 2, 4), suggesting it was mandatory. One document (2), stated that there was a need for a whole service commitment and approach and so it was very important that training was mandatory for all staff, including leaders and medical staff. Another document described 'Facilitating Recovery' as a core module in a graduate diploma in mental health (29).

ENVIRONMENT / WHERE

Not many documents were clear as to the environment the training was delivered, however, those that did, highlighted the importance of their venue. One document stated their training took place on the hospital site, explaining the practical importance of allowing for maximum staff attendance, without disrupting staff delivery (3).

However, another document stated training was held in a community centre, not a hospital, to avoid the training seen as a managerial initiative and to prevent the over

identification of recovery within NHS hospital premises (5, 6). Another training programme stated the importance of a 'Skills Lab' to provide an environment to practice the new skills (1). It was not clear if the Skills Lab was a hospital style environment.

Online or e-learning was also discussed, although only one document actually described delivering e-learning within a recovery training programme and this was for individuals undertaking assessments of what they had learnt (39). Articles argued that e-learning allowed students to construct their own teaching and learning opportunities. This could allow for student led discussions, scenario based learning and exploring value based practices, which could be used to teach recovery (32). Another document addressed computer learning, using videos and the internet for learning. However, potential problems identified included, participants lacking adequate computer skills, internet connections being slow and a lack of memory space on the computer (33).

PREPARATION OF PARTICIPANTS

All documents that discussed the preparation of participants identified the importance of providing more information prior to the training (2, 3), especially for managers. Advance reading from the 'lived experience' of service user literature prior to the start was described as beneficial (2). Suggestions of providing an outline of the course, aims, objectives and structure before the start were suggested as useful for preparation (2).

5.4 Key content

START of TRAINING

The content at the start of the training fell into one of two categories, either examining what is recovery or the historical context of services and recovery (1, 2, 5, 6, 7, 8, 11, 12, 14, 17, 27, 28, 30, 49). Exploring what is recovery often involved exercises examining participants' personal experiences allowing them to understand what recovery is, what recovery is not and different definitions (2, 5, 6, 7, 8, 12, 14, 17). Looking at the history of mental health services over the last 200 years and the service user movement over recent years, allowed participants to understand why the recovery agenda has come about, the philosophical foundations of the recovery approach and how to reconstruct practices to include recovery values (1, 2, 9, 11, 29, 44).

SERVICE USER STORIES

A key part of all training and education programmes was the use of service user stories of the 'lived experience of mental distress' (16, 21, 27, 29, 38, 45, 49). Documents suggested that by hearing stories of recovery directly from people who have recovered (38), there was a move towards seeing the humanity rather than the symptoms. Stories included service user's experiences (21, 27, 49), treatment, coping, diagnosis, success, hopes and dreams (16). Practitioners were able to learn about service users, develop a genuine curiosity and interest of their unique experience (45) and begin to learn a new language that both service users and professionals understand.

LANGUAGE

A large proportion of training looked at language and the impact of different language upon recovery (1, 2, 16, 28, 45, 49, 50, 51). By looking at the importance of language participants were able to learn how to reconstruct realities of mental illness. One evaluation highlighted the importance of demonstrating how to use recovery language and working with it in practice (16).

PERSON CENTRED PLANNING

Another key area addressed throughout all recovery training was person-centre planning (1, 5, 6, 11, 19, 21, 46, 47, 51). This involved ensuring the service user is the centre to all planning and care. Forming a unique partnership of respect, dignity and trust and providing choice for service users to plan their own care. This led to a number of potential fears for practitioners in relation to risk, which will be addressed further in this report. Many of the documents outlined different tools that practitioners were taught about how to provide person centred planning from a recovery perspective. Guiding and supporting service users to look at their story, dreams, nightmares, community resources, gifts, strengths, talents, skills, needs and action. Many documents drew on the strengths model, providing examples of strength assessments, goal planning and personal plans.

TOOLS FOR PLANNING RECOVERY

Many documents provided training for professionals with tools to work with service users in a person centred, recovery focussed way (5, 6, 11, 17, 21, 30, 42, 44, 45, 47, 48, 51). This often involved providing practitioners with tools to focus on service user strengths, strategies to cope, setting goals and providing service user's with a toolkit of resources. Tools include (5, 6, 17, 21):

- GROW (Goal – Reality – Options – WrapUp)
- COPS (Choice – Ownership – People – Self)
- PATH (Planning – Alternative – Tomorrow – with Hope)
- TAAP (Treatment – Accommodation – Aspirations – Development)
- SHIRE (Safe – Holistic – Integrate – Recovery – Environment)
- Crisis PATH (72 Hour Crisis Intervention)
- Crisis Contingency Planning
- Planning (Life Story – Dreams – Nightmares)
- Quest (Positive – Potentials – Passions)
- Circles of Support (Intimacy – Friendships – Participation – Exchange)
- Time for recovery

Another area of planning included psycho-education approaches, mainly using the Wellness Recovery Action Plan (WRAP) (4, 5, 6, 8, 9, 11, 30, 47, 49). Training on how to use WRAP was often incorporated within recovery training programmes, addressing many the following topics:

- Introducing WRAP
- Completing a WRAP Plan
- Understanding the purpose and function of WRAP
- Developing a Wellness Recovery Toolbox
- Daily Maintenance Plans
- Identifying Triggers
- Early Warning Signs
- When things are breaking down
- Crisis Planning
- Psycho-education
- Psychological strategies
- Anti-psychotic medication

Other plans, included, Crisis Plans and Wellness Plans (9); Cognitive Behavioural Therapy, psycho-educational and problem-solving (47); and different forms of therapies (5, 6).

RELATIONSHIPS

Another focus of recovery training was considering relationships and new ways of relating to people (1, 2, 5, 6, 11, 42, 43, 44, 47, 51). Looking at how to increase meaningful involvement (1), work with service users to build trust, hope, and overcoming barriers of engagement (11, 47). How to form empowering partnerships between service users and professionals rather than having treatment imposed (5, 6, 42, 43, 51). Forming human connections where individuals are given choice and support in their care, facilitating the feeling that hope of recovery is possible (1, 2, 5, 6, 44, 51).

RISK & SAFETY

An area highlighted later in training programmes addressed the issues around risk and safety (5, 6, 10, 11, 17, 18, 28, 44). Considering areas of high risk and low risk and how to take positive risks, yet provide a safe and secure environment.

A couple of documents (28, 67) considered the concerns of practitioners in promoting recovery yet providing a safe environment. How to work with someone within recovery when they are having an acute episode of psychosis or how to focus on strengths, hopes and dreams when the individual needs safety and stability. Another area addressed was how practitioners could promote service user choice and self determination, yet be responsible for adverse events of the service user. The article suggested that one solution was to restructure care from the professional's perspective to the service user's perspective. Therefore, the recommendation was to look at the role of treatment in recovery rather than the role of recovery in treatment, and so learning to work together to reduce risk.

STIGMA & DISCRIMINATION

A number of the training programmes addressed stigma, discrimination and social exclusion (9, 10, 24, 27, 38, 42, 51), which were described as a key to developing recovery practices. Hearing stories of service users directly talking about their recovery was identified as one of the key areas to help reduce stigma and discrimination. A few journal articles (42, 51) highlighted the need for mental health professionals to change their perceptions and values and work together to challenge stigma across services.

Other areas that some training addressed included:

Trauma and Psychosis

Two training courses addressed the issue of trauma and psychosis. One four day training course in Scotland involved a service user trainer using a DVD to stimulate discussion around trauma, psychosis and hearing voices (6). Training in Auckland, New

Zealand, presented the 'Map of the Journal of Re-recovery Spiritual Context' model (47), which identified clear links between trauma and recovery. The model highlighted that trauma can occur from a variety of experiences including sexual abuse, neglect, bullying, invalidation, war and natural disasters. The model looked at stress vulnerability and how trauma can trigger voice hearing, delusional beliefs and psychosis. It also highlighted ways to address this through biological, psychological, social, spiritual and culture interventions (66).

Documents suggested that within New Zealand there is an increasing interest in the affects of sexual abuse and other traumas on psychosis. Researchers at the University of Auckland have developed training for mental health staff to develop skills to work with people who have experienced trauma to help decrease distress (47). This is an area that is still in its infancy, but to help people with recovery, this subject matter will need to be addressed in the future.

Rehabilitation and Recovery.

There was an element of misunderstanding of rehabilitation and recovery within some of the documents, which was also highlighted in some of the training programmes, an area, which practitioners need to be aware of (38). Training led by psychiatrists or government based organisations, often demonstrate this misunderstanding (22, 23, 26, 28). The importance of rehabilitation not simply being redefined as recovery was noted (67). Rehabilitation has been defined as 'living as normal a life as possible, following a defined framework of optimising function in social, vocational, symptom management, activities of daily living and accommodation. People progress through a predetermined programme to allow them to function effectively in society' (23). Where as recovery is the real experience of the individual as they accept and overcome the challenge of their experiences (28).

Additional Training for Managers

A number of documents identified that the biggest challenge in training participants within recovery was ensuring they use the skills, knowledge and values in practice (1, 2, 64, 67). Problems with recovery structures not being in place, for example planning, documentation and assessments posed some of the biggest problems for managers to ensure successful implementation (2). One evaluation found that the poor success regarding the implementation of the training programme was that managers lacked the recovery vision (3).

A number of training courses, provided training for managers, prior to the rest of the team (1, 2, 4, 5, 6) to try and ensure a more successful implementation. One document provided an outline of the content of the managers training (1, 2), which is as follows:

- Exploring ways to sustain recovery.
- Addressing policies & procedures.
- Reviewing tools / processes currently used.
- Consideration of barriers to deliver recovery-orientated practices.
- How to develop recovery language and focus through the team. For example putting recovery on the agenda in all meetings.
- Changing paperwork, assessments, outcome measures, risk assessments to be more in line with recovery practices.
- Changing management plans.
- Realising that managers don't have all the answers, but by working together, they can be found.

Another document, stated the importance of portraying hope that recovery-orientated practices do work, which could be demonstrated by a nurse unit manager talking about the positives of recovery-orientated practices (2).

What recovery services would look like?

Two training courses provided participants with an idea on what an effective recovery-orientated service could look like (6, 14, 15). This included:

- A service that meets the needs of individuals.
- A change in focus from illness to a focus on the individual's unique needs.
- Treatment and support focusing on individual's Strengths not their problems.
- A shift in accountability from, Professionals being accountable to individual's taking a personal responsibility.
- Focusing on people's experiences not their diagnosis.
- Ensuring equality for everyone.
- Ensuring individuals are given the support, knowledge and skills to access the same services and opportunities that everyone can access.
- Work with people to help them recognise individual networks and supports.

5.5 Examples of national roll-out

No examples of national roll-out were found in the literature searched. The Midland Region Mental Health and Addiction service in New Zealand has developed a training course across five district health boards, which is probably one of the largest roll-out examples identified (4, 63). The evaluation of the training in Bayside Mental Health Services, Australia stated that there would need to be careful consideration to roll-out their training approach nationally. The evaluation identified the importance of a carefully selected team of trainers, which would have the qualities and training needed for implementation (2).

In comparison, the New Zealand Mental Health Commission developed a 'Teaching Resource Kit' for teaching National Recovery Competencies (9), which was rolled-out throughout New Zealand. The Resource Kit, provided resources for trainers to use including teaching notes, relevant national documents and legislation (on a CD ROM), overhead transparencies, class activities, service user stories for discussion, a book of

collected articles and guidelines for inviting service users and family members as guest trainers.

Another, New Zealand, resource for National roll-out, was the 'Like Minds, Like Mine' project, to tackle stigma and discrimination (31). This trainer's toolkit, followed a similar approach to the Recovery Competencies resource kit, providing many examples (with handouts) of ice breakers, role-plays, drama, warm-ups and objective specific activities, all specifically formed as exercises to address the subject material. Unlike the Recovery Competencies resource kit, this resource also provided information on evaluation (with questionnaires), certificates (for participants) and considered adult learning and teaching techniques (31).

5.6 Impact on practice

Most evaluations of training programmes have looked at the training programmes themselves, with few investigating the impact of the course on practice. Bayside Mental Health Services, Australia carried out an evaluation of training that involved 256 practitioners (support staff, nurses, allied health professionals & medical staff) (1, 2). The training and evaluation was undertaken across different mental health services within the surrounding area. The evaluation found that the two most important areas of the training were that participants learning about themselves and their practice and learning how to develop recovery focused language. The evaluation which also looked at the impact of the training course on practice after 6 months, found that it had led to an increase service user involvement in care plans and treatments, encouraged practitioners to attain their goals and ensured a person-centred approach. Staff felt they had better communication with other health professionals and their language was more recovery focused. At the end of the training, participants were significantly more confident in their ability to participate in a range of recovery based activities.

The 6 month follow-up indicated that the training had had a significant impact, changing attitudes and increasing the knowledge of participants who had attended the training, with participants practicing recovery in their daily work. Hearing service user stories, helped staff change their attitudes, and had a positive affect on their interactions with service users (1, 2).

Another evaluation of training in Scotland, found that the training changed perceptions and understanding of participants, provided a good networking opportunity and improved confidence and knowledge of recovery (3). However the evaluation also found that there was a lack of success in relation to implementation into practice, due to their being little guidance on how to take recovery forward and be implemented. Although, participants had recovery knowledge, the training had not given them the skills and knowledge of how to implement recovery in practice. The key reason for poor success of implementation was that managers lacked the recovery vision for a successful implementation.

5.7 Accreditation Issues

No documents addressed the area of accreditation.

6.0 Discussion

A variety of different training styles were used depending on the purpose of the training. However, the most significant was that of using an experiential style, allowing participants to reflect upon their own life journey and see situations from a different perspective. The use of experiential methodology would therefore be recommended. There were a variety of different tools to help participants learn, including PowerPoint presentations, role-plays, exercises and DVD presentations. The use of a variety of learning tools, optimised learning, therefore this would be recommended.

The number of trainers included in the review varied, with no clear trends, it is therefore impossible to offer a recommended number of trainers. However, there was some suggestion that recovery training courses were quite intense to expect one person to facilitate it alone. Hearing the lived experience from service users was very effective in portraying the message. This would strongly suggest that service users and carers should be involved within training and service users stories used throughout training courses. The literature would also suggest that trainers complete a 'training for trainers' course and not simply, read recovery documentation to qualify as a trainer. The evidence also indicated that training is most effective by either an independent organisation or health boards, therefore this is recommended.

The variations in length of training courses included in this review were considerable therefore it is impossible to offer a recommended length of training course. The majority of courses included, however, did offer follow up training and saw this as important for the continuing development of participants.

Training was unanimously interprofessional, with service users and carers also present, which is recommended. The review indicated interprofessional learning would ensure the whole team are involved in the recovery training, including medical staff and

managers which is crucial for successful implementation. There was no clear indication of the most effective number of participants in a training course, however, on average a maximum of 20 participants were trained.

There was a variation in the review of the environment within which training took place and so it is impossible to offer a recommendation, however, the ability to practice skills, was important to increase learning and so is recommended.

There was a large variation on the content of the training, however, there were some themes running through all training, which would be recommended. These were:

- Exploring the meaning of recovery with reference to historical context.
- Service user stories, allowing participants to move away from working with symptoms.
- Language, exploring different discourses to construct a joint recovery language.
- Person centred planning, placing service users central to all planning and care.
- Tools for planning recovery, providing practitioners and service users ways to work together.
- Relationships, focusing on human connections and partnerships.
- Risk and Safety, addressing accountability and responsibility.
- Stigma & Discrimination, challenge barriers of social exclusion.

Implementing recovery training into practice was highlighted as a major issue. The literature would suggest that this is a key area to be considered when developing recovery training, which could include additional training for managers, addressing changing systems, language and ways of working.

6.1 Conclusion

The literature review and documentary analysis which has been undertaken on recovery training in mental health practice has produced some interesting results, which need to be considered when developing a training framework. For recovery training to be developed, many areas will need to be considered, not only within the training programme but its implementation in practice.

If recovery orientated practices are to be successfully developed with all mental health nurses, changes throughout the entire service need to be addressed. Research has shown that by learning to connect, communicate and understand the roles of other professions, services and teams will begin to work more cohesively. By hearing stories of the lived experience, nurses will need to adjust the focus of their work, learning from service users and working with them to meet their needs.

However, most importantly, there will need to be major organisational changes to challenge policies and procedures that prevent recovery practices. Recovery, not treatment, will need to be placed at the centre of all practices, enabling the formation of a service where practitioners work to support and facilitate service users in a recovery focused way.

6.2 Limitations of the review

There have been a number of limitations to this review.

- (1) The main limitation is a lack of time to fully explore all literature available, especially grey literature. A large number of unpublished documents were collected via email and this process could have continued with more time. Short deadlines were set for the collection of documentation and reading materials, which limited a full analysis.
- (2) The review only included documents that focused on training mental health professionals in recovery. Training for service users and Peer Support Workers were excluded. This resulted in many documents being excluded, especially from the United States of America.
- (3) As the time frames of the project were tight, the search terms were set prior to starting the project and were not adjusted following initial results. This was decided to ensure the project would be complete within the timeframe. However, it reduced the scope of the review.

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- (59) Cath Roper, Consumer Academic, Centre for Psychiatric Nursing, School of Nursing, University of Melbourne, Australia – Email
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Appendix 1 – Letter emailed through Personal Communications

AskClyde

MORE THAN RESEARCH AND CONSULTANCY

Clydebank Social Economy Centre

63 Kilbowie Road

Clydebank

G81 1BL

29th January 2007

Re: Recovery Training in Mental Health Practice

Dear Sir/Madam,

I am writing to you, about a project AskClyde is involved with across NHS Education for Scotland and the Scottish Recovery Network. The project is part of the overall implementation of the actions contained in *Rights, Relationships and Recovery* (Scottish Executive, 2006), the national review of mental health nursing in Scotland.

The overall aim of the project is to provide an outline framework for training/education for mental health nurses in relation to recovery.

AskClyde are currently gathering national and international information / literature for analysis to help form this framework and wondered if you could send us relevant documents for this search. This does not have to be specific to nurses and can include any group of people. We want to gather evidence to inform the following areas:

- Training / Educational methodology
- Preparation of trainers
- Delivery – who, where, when
- Key content
- Examples of national roll-out
- Impact on practice
- Accreditation issues

Material / documents can include, training/education materials, handouts, evaluation reports, published and/or unpublished articles, teaching plans and any documents you might think is relevant.

The timeframe for this piece of work is short. All materials to be sent by **Friday 16th February 2007**, to jim.campbell@askclyde.co.uk

If you have any questions or comments please don't hesitate to contact me. Feel free to circulate this letter to your colleagues and contacts.

With Kindest Regards

Jim Campbell
Research & Development Officer

Appendix 2 – Different courses analysed (country, organisation, location, reference)

COUNTRY	ORGANISATION	LOCATION	REFERENCE
New Zealand	Midland District Health Board	5 DHBs	(4, 63)
New Zealand	Mental Health Commission of New Zealand	Wellington	(9)
New Zealand	South Canterbury District Health Board	Timaru	(11)
New Zealand	Northland Health District Health Board	Whangarei	(30, 64)
New Zealand	LMLM Training and Education Group	New Zealand	(31)
New Zealand	Keepwell New Zealand Ltd	New Zealand	(54)
New Zealand	Buchanan Rehabilitation Unit	Auckland	(39, 47, 48)
New Zealand	Regional Forensic Psychiatric Services	Auckland	(52)
New Zealand	Action for Mental Health	New Zealand	(57)
New Zealand	Case Consulting	Wellington	(53)
UK	National Institute for Mental Health	England	(8, 14, 20)
UK	Care Services Improvement Partnership	England	(7)
UK	Royal College of Psychiatrists	UK	(25, 61)
UK	Working to Recovery	Scotland	(3)
UK	Tayside Recovery Training Group	Dundee	(5, 6, 15, 17, 18, 19, 21)
UK	NHS Greater Glasgow Primary Care Division Mental Health Services	Glasgow	(36)
UK	North West Recovery and Values training group	Manchester	(27, 60)
UK	School of Nursing, University of Nottingham	Nottingham	(49)
UK	Crazy Diamond	Merseyside	(62)

Australia	Bayside Mental Health Services	Queensland	(1, 2)
Australia	Centre for Psychiatric Nursing, University of Melbourne	Melbourne	(12, 13, 37, 51, 49)
Australia	North West Mental Health Services	Melbourne	(26, 55)
Australia	Rozelle District Health Board	Sydney	(28, 29, 33)
Australia	Queensland Mental Health Services	Queensland	(56)
Australia	Mental health Coordinating Council Inc.	NSW	(58)
Australia	Keepwell Australia Pty Ltd	Australia	(35)
America	National Empowerment Centre	Massachusetts	(10, 38, 44, 65)
America	National Alliance on Mental Illness	Virginia	(16)
America	The American Psychiatric Association	Virginia	(23)
America	National Institute of Mental Health	Maryland	(34)

Appendix 3 – Who were the trainers? (country, organisation, reference)

COUNTRY	GOVERNMENT FUNDED	EDUCATION INSTITUTES	INDEPENDENT ORGANISATIONS	VOLUNTARY / NGO ORGANISATIONS	HEALTH BOARDS
AUSTRALIA		(12, 13, 37, 51, 59)	(35)	(58)	(26, 55) (56) (1, 2) (28, 29, 33)
NEW ZEALAND	(9)		(31) (53) (54)	(57)	(4, 63) (52) (30, 64) (11) (39, 47, 48)
UNITED KINGDOM	(8, 14, 20)	(49)	(27, 60) (62) (3)		(5, 6, 15, 17, 18, 19, 21) (25, 61) (7) (36)
UNITED STATES OF AMERICA	(23) (34)			(10, 38, 44, 65) (16)	
TOTAL	4	2	7	4	13

(#, #, #) = multiple documents about one training/educational course