

Recovery-Oriented Training and Staff Attitudes Over Time in Two State Hospitals

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Accepted version; Final version published as Tsai, J., Salyers, M. P., Lobb, A. L. (2010).
Recovery-oriented training and staff attitudes over time in two state hospitals. *Psychiatric
Quarterly*, 81, 335-347.

Abstract

Recovery attitudes and concepts are often promoted to community mental health staff through educational and in-service trainings, but no study found has examined this in state hospitals. The current observational study aimed to examine the types of recovery-oriented trainings that occurred at two state hospitals over one year and subsequent changes in staff recovery attitudes. A total of 184 state hospital staff completed questionnaires assessing their personal optimism, consumer optimism, and agency recovery orientation at baseline and 1 year later. The types of recovery-oriented trainings staff received were categorized as general/inspirational or specific/practical training. Results found that the majority of staff at the two state hospitals received some recovery-oriented training, mostly general/inspirational training. Staff who received specific/practical training had a greater increase in agency recovery attitudes than staff who received only general/inspirational training or no training. However, the more trainings staff had, the higher their consumer optimism. These results suggest state hospitals are incorporating recovery-oriented staff trainings, but more specific trainings may be needed and all staff involved in different levels of care need to be included.

Keywords: Recovery; Staff Training; State Hospitals; Psychiatric Rehabilitation

With the deinstitutionalization of people with mental illness in the 1960s and the closing of many state psychiatric hospitals, mental health services shifted to a community-based model of care in the United States. Soon thereafter, a burgeoning movement towards recovery-oriented mental health care began (1). The concept of recovery is defined as helping people with severe mental illness live productive and meaningful lives in spite of their illness; implied in this definition is the goal of independent living in the community. However, many people with severe mental illness experience episodes of hospitalization, homelessness, incarceration, and other problems that require some institutional care. It is during institutional care that recovery-related concepts, such as hopefulness, may be critical. Unfortunately, as the recovery movement was mostly borne out of an era that began to shun state hospitals, efforts to transform systems of care to be more recovery-oriented have focused on community mental health providers (2). However, public psychiatric hospitals are still in every state serving over 150,000 people with mental illness annually (3). State hospitals are still very much in use and represent an important part of the continuum of care (4,5).

Studies have shown that staff working in state hospitals report lower optimism regarding consumers and lower agency recovery orientation than community providers (6,7). The reasons for these findings are likely multifaceted, but the findings do point to a need for more education and intervention if the recovery movement is to expand to hospital-based care. The mental health field has spent considerable effort defining, conceptualizing, and measuring recovery (8-11). Many are making efforts to develop interventions to enhance recovery-oriented care. These interventions often take the form of education and staff in-service training (12).

In-service training can provide opportunities for mental health staff to learn new skills and hear different perspectives on client care. In-services have often been used to educate staff on three types of information: 1) to help staff learn attitudes that reflect a community-focus to treatment, consumer empowerment, and recovery, 2) to help staff gain knowledge about psychiatric illness, medications, and the range of psychosocial treatments available, and 3) to help staff master a variety of skills that comprise the actual practice of rehabilitation (13). Some trainings are conducted mostly by researchers and clinicians (14), others are solely directed by consumers (15). A randomized controlled trial (16) found that staff educated by a consumer trainer had more positive recovery scores than did those by a non-consumer trainer. However, there has been little comparison between types of recovery trainings and there exist no typology

to characterize different trainings. The current study mainly focused on comparing trainings that provided the 1st type of information (i.e., help staff learn attitudes that reflect a community-focus) and the 3rd type (help staff master skills that comprise rehabilitation).

The success of various recovery trainings and programs has begun to be documented in community mental health centers (17,18), but less so in state hospitals. Although there has been considerable research specifically on reducing the use of restrictive interventions, such as seclusion, restraint, and benzodiazepines (19), trainings more broadly related to recovery in state hospitals have not been well-studied. There have been a few demonstration projects (20-22) that have generated interest in this area. However, no study could be found examining the types of recovery training in state hospitals, nor their impact on staff attitudes.

The current observational study examined the types of recovery-oriented training at two state hospitals and the impact of the training on staff recovery attitudes. We roughly categorized recovery-oriented trainings into two categories: general/inspirational training and specific/practical skills training. Although this was largely an exploratory study, we hypothesized that specific/practical skills training would have a greater positive impact on the recovery orientation of the agency and recovery attitudes of staff than general/inspirational training or no recovery-oriented training. The rationale behind this hypothesis is that teaching specific/practical skills may change behavior, which may have more of an effect on staff attitudes and organizational practices than training that is general or mostly inspirational, which do not necessarily teach behavior changes directly.

Methods

Study Design

Staff at two state hospitals in Indiana were invited to participate in this study. Hospital staff were told that we were interested in staff members' perceptions of processes within their organization. A packet of questionnaires assessing recovery attitudes were distributed to hospital staff by clinical administrators at the two hospitals. One year later, hospital staff were asked to complete the same questionnaires and to complete an additional form asking about the types of recovery-oriented training they had received in the past year. Participants were not paid for completing questionnaires and were ensured of the confidentiality of their responses. Completed questionnaires were returned directly to the research staff with self-addressed stamped

envelopes. All procedures were approved by the Institutional Review Board at Indiana University-Purdue University Indianapolis.

Approximately 700 staff (300 from hospital A and 400 from hospital B) were initially invited to participate in this study, and 193 staff (64.3% response rate) from hospital A and 234 staff (58.8% response rate) from hospital B completed questionnaires at baseline. Two-hundred six staff from hospital A and 187 staff from hospital B completed questionnaires at 1-year follow up. However, there were only a total of 184 (98 from hospital A and 86 from hospital B) staff who completed questionnaires at both baseline and 1 year follow-up that could be linked. These 184 staff were the focus of this study in order to examine change over time.

Training Descriptions

Recovery-oriented training was grouped into one of two categories: specific/practical skills training or general/inspirational training. General/inspirational training included Roadmap to Seclusion and Restraint Free Mental Health Settings, “comfort room” workgroups, “bridge building”, and Respect seminars. Roadmap to Seclusion and Restraint Free Mental Health Settings is a 3-day workshop based on modules developed by SAMHSA (23) which engages staff to think about their practices. Comfort rooms are individual projects on hospital units where staff are planning rooms to provide a calming environment for clients to relieve stress, which have been proposed to reduce the use of restraints and seclusion (24). Bridge building is a certification program for staff aimed at de-escalation techniques and emphasizes use of the least restrictive methods necessary. The Respect seminar is a 1-day presentation by a private consultant and former consumer, Joel Slack, who is a well-known speaker on recovery (25).

Specific/practical skills training included trainings on Illness Management and Recovery, Integrated Dual Disorders Treatment, Wellness Recovery and Action Planning, the Matrix model, and motivational interviewing. Illness Management and Recovery (IMR; 26) is a curriculum-based treatment approach focused on teaching consumers how to set and achieve personal recovery goals, acquire knowledge, and use skills to independently manage their illnesses. Integrated Dual Disorders Treatment (IDDT; 27) teaches staff to provide mental health and substance abuse interventions together based on clients’ stage of treatment and readiness to change. Wellness Recovery Action Planning (WRAP; 28) teaches staff to engage clients in their own care and personal goals by helping them develop specific recovery plans. The Matrix model (29) is a structured treatment approach for substance abuse that staff can use to provide

information and relapse prevention techniques. Motivational interviewing (30) teaches staff how to use their clients' motivations and resources to change their behavior.

Participants were then grouped into whether they had received 1) only general/inspirational training, 2) specific/practical training, or 3) no recovery-oriented training. There were only 4 participants who had received specific/practical training without also participating in a general/inspirational training. Because this type of training usually addresses general concepts of recovery, we reasoned that the inclusion of these 4 staff was warranted.

Recovery Measures

We were interested in assessments of how staff view themselves, how they view consumers, and how they view their agency in relation to recovery orientation. We chose instruments to tap each of these levels.

Personal Optimism. The LOT-R is a self-report measure commonly used for research on optimism and pessimism (31); we used an 8-item version used in a previous study on staff recovery attitudes (Salyers, Tsai, & Stultz, 2007). Respondents were asked to indicate their degree of agreement with statements such as "I hardly expect things to go my way" and "I rarely count on good things happening to me" using a 5-point response scale ranging from 1 (strongly disagree) to 5 (strongly agree). Scores were totaled to yield an overall optimism score with high scores representing greater optimism. Previous research has shown convergent validity with related scales, high test-retest reliability, and high internal consistency (6,32). In this study, there was good internal consistency with an alpha of .71.

Consumer Optimism. The Consumer Optimism scale consists of 16 items tapping the provider's expectations of consumers. A previous 7-item scale measuring optimism regarding patients (33) was expanded by adding items to include broader domains of recovery, including medication use, drug and alcohol use, housing, and competitive employment. Staff are asked to think about consumers they currently work with and to answer on a 5-point scale from 1 (Almost All) to 5 (None) how many consumers they would describe with statements such as, "will remain in the mental health system for the rest of their lives" and "will be able to function very well in the community." Excellent internal consistency and test-retest reliability over a 2-week period has been found for this scale (6). Excellent internal consistency was found in this study with alpha= .91.

Agency-Level Beliefs. The Recovery Self-Assessment (RSA; 9) is a set of scales developed to gauge the degree to which programs implement recovery-oriented practices. We used the provider version scale in this study. The 36-item instrument reflects practices that are associated with conceptual domains of recovery. All items consist of a brief statement with a Likert response from 1 (strongly disagree) to 5 (strongly agree) with higher numbers reflecting greater recovery orientation. The RSA consists of five factors. Factor 1: Life Goals refers to the extent to which staff help with development and pursuit of individually defined life goals. Factor 2: Consumer Involvement refers to the extent consumers are involved in the development and provision of programs/services, staff training, and advisory board/management meetings. Factor 3: Diversity of Treatment Options refers to providing linkages to peer mentors and support, a variety of treatment options, and assistance with becoming involved in non-mental health activities. Factor 4: Client Choice refers to the extent to which staff refrain from using coercive measures, provide consumers with access to treatment records, and have clearly defined exit criteria. Factor 5: Individually-Tailored Services refers to the degree to which services are tailored to individual needs, cultures, and interests. Good internal consistency within the five factors and excellent test-retest reliability has been previously found (6,9). In this study, we found good internal consistency with alphas of .88, .83, .76, .72, and .74 for each of the five factors, respectively and an overall scale alpha of .95.

Data Analysis

Demographics, amount of training, and baseline values of all recovery measures between hospitals were compared using t-tests and Chi-square. Levene's test for equality of variances was used and appropriate corrections were made to t-tests. Pearson correlations were conducted between demographics, number of trainings, and recovery measures at 1-year follow-up. A repeated measures analysis of covariance (ANCOVA) with a between-subjects factor was used to compare participants who received different types of recovery-oriented training. Demographics that were correlated with recovery measures were controlled for by entering them as covariates along with site (dummy variables were created for categorical variables) and a full factorial model was specified.

Results

Table 1 shows the types of recovery-oriented training conducted at each hospital. Staff in each hospital had several different types of training, involving practical/specific training and

general/inspirational training. There was no training common to both hospitals, except the Respect Seminar, but the majority of staff at both hospitals received some recovery training.

The demographic characteristics, recovery-oriented training, and baseline recovery values for all participants are shown in Table 2. There were significant differences between hospitals found on age, position, the consumer optimism scale, and mean number of total trainings during the study year. The majority of participants at Hospital A and B had general/inspirational training, while only about 20-25% had both general/inspirational and specific/practical training. When trainings by position were examined, 52-77% had general/inspirational training, but only 15% of attendants, 18% of nurses, and 27% of social workers had specific/practical training.

Table 3 shows the correlations between demographics, number of trainings, and recovery measures at 1 year. Participants with higher levels of education had significantly higher scores on the personal optimism scale and the consumer optimism scale, but lower scores on Factor 2: Consumer Involvement, Factor 4: Choice, and Factor 5: Individual Services of the RSA. Other significant correlations showed that participants who were White had significantly higher scores on the total RSA; participants with more years in their position had significantly lower consumer optimism scores; and the more trainings participants had the higher their consumer optimism scores were. There was no significant correlation between number of trainings and personal optimism, or RSA scores.

Table 4 shows the recovery measures of participants over the 1-year period of study. A repeated measures ANCOVA, controlling for education, race, years in position, and hospital site correlated with recovery measures, found no significant differences between training types (between-subjects factor). However, there were significant time effects (within-subjects factor) indicating improvements on the total RSA, including Factor 1: Life Goals, Factor 3: Diversity of Treatment, Factor 4: Choice, and Factor 5: Individual Services.

There were significant interactions between time and training type (interaction effect) on Factor 1: Life Goals and the total RSA. Post-hoc ANCOVAs showed that participants who had specific/practical training showed a larger rate of increase in scores over time (interaction effect) on the total RSA and Factor 1: Life goals than both participants who had general/inspirational training only and those who had no training ($p < .05$). This is illustrated in Figure 1. There was no significant difference in the rate of increase on scores between participants who had general/inspirational training only and those who had no training.

To examine the suppression effects of covariates, the above analyses were repeated with no covariates included in the model using ANOVAs. Results were similar, except one additional significant time effect was found on RSA Factor 2: Consumer Involvement.

Discussion

This is one of the first studies to document the types of recovery-oriented training staff receive in state hospitals. In this observational study of two state hospitals in Indiana, it was found that the majority of staff received some recovery-oriented training over a 1-year period and various kinds of recovery training were offered. This finding may be indicative of a larger trend among other state hospitals. We know, at least in Indiana, state hospitals are beginning to incorporate recovery not only through trainings, but other aspects of their clinical care such as introducing “person-first language” in electronic medical record forms, applying for transformation grants, and systematically assessing client satisfaction.

We roughly categorized recovery-oriented trainings as specific/practical or general/inspirational. The results partially supported our hypothesis by showing staff who received specific/practical training had a greater increase in recovery attitudes about efforts to help clients pursue their own life goals and an overall greater increase in staff beliefs about their hospital’s recovery orientation than staff who received only general/inspirational training or no training. General/inspirational trainings may have less “staying power” because they can abstract and do not always translate directly to clinical techniques. In contrast, specific/practical training may present staff with various “hands-on” methods and techniques that they can use as part of their client care, such as personal goal setting. Although didactic training alone is insufficient to build skills and promote actual changes in behavior (34), interactive methods and the use of non-print media, multiple types of media, and multiple exposure to the material are also promising methods of imparting new practice information (35).

Although nearly all staff received some recovery-oriented training, there was no significant difference in consumer optimism over time. Given that studies on recovery-oriented training in community-based settings have led to significant positive changes in attitudes about clients (18) and findings that staff in state hospitals have significantly lower consumer optimism than community staff (7), it may be that expectations about consumers are more recalcitrant in state hospitals. There may also be differences between the “voluntary” clients in the community and “involuntary” clients in state hospitals, as clients in state hospitals are often there not of their

own choosing. This may impact staff perceptions and attitudes, as some clients have long lengths of stay in state hospitals and have previously demonstrated difficulties living in the community. However, correlational analyses did reveal that the more recovery-oriented trainings staff had, the higher their consumer optimism.

A variety of staff positions were included in this study, but it is likely that the specific/practical trainings listed were geared more towards staff who provided counseling or psychologically services (e.g., behavioral clinicians, psychologists, social workers). In fact, we found that among attendants, who were the largest group of participants, only 10 (15%) had specific/practical training in the past year. Yet attendants are often the staff members that have the most interaction and potential influence on clients' day to day lives in the hospital. Further research is needed on the types of training in state hospitals and how they can be best tailored to different positions.

This study had several limitations worth discussing. Because almost all participants received some type of recovery-oriented training, there was only a small group of participants who reported no training at all during the prior year. This limits our ability to detect differences between the no training group and others.

Both of the two state hospitals were in Indiana and it is unknown how the results may generalize to other state hospitals. Also, we created a simple dichotomy between general/inspirational and specific/practical training, but there may be more accurate, complex ways to examine types of trainings. The longitudinal impact of trainings and the organizational forces behind efforts to be more recovery-oriented need more attention in state hospitals. Although we have described some movements in these two state hospitals to be more recovery-oriented, we still have some distance to go. For example, in one of the state hospitals, 15% of clients have stayed longer than 20 years. However, it is often the community mental health providers, acting as gatekeepers, who advocate for continued hospitalization due to limited resources in their communities. Changes may need to occur at the systems level with all stakeholders involved before state hospitals can really move towards a recovery orientation. Clearly, more research is needed on how to transform our state hospitals in an era of recovery.

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Table 1. Summary of Recovery-oriented Trainings by Hospital over 1-year period

Hospital A (n= 98)	Number of Staff Received Training
Any Recovery Training	78 (79.6%)
General/Inspirational Training	
1. Respect Seminar	83 (84.7%)
2. Other (conference, seminars)	4 (4.1%)
Practical/Specific Training	
3. 2-day training on Illness Management and Recovery	11 (11.2%)
4. Motivational interviewing	11 (11.2%)
5. Clinical Supervision of Motivational Interviewing	25 (25.5%)
	6 (6.1%)
Hospital B (n= 86)	Number of Staff Received Training
Any Recovery Training	81 (94.2%)
General/Inspirational Training	
1. Roadmap to Seclusion and Restraint Free Mental Health Settings	80 (93.0%)
	30 (34.9%)
	39 (45.3%)
2. Comfort Rooms	6 (7.0%)
3. Respect seminar	
4. Other (family-based interventions, reading, conferences, meetings)	
Practical/Specific Training	
5. Wellness Recovery and Action Planning	18 (20.9%)
6. Integrated Dual Disorders Treatment	5 (5.8%)
7. Matrix model for Substance Abuse	1 (1.2%)