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BRIEF REPORT

Italian Investigation on Mental Health Workers' Attitudes Regarding Personal Recovery From Mental Illness

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Abstract
This study aimed to investigate attitudes toward personal recovery in a sample of 436 healthcare professionals and students of psychiatric rehabilitation techniques through the Italian version of the recovery knowledge inventory (RKI). The sample in our study showed a good global orientation toward recovery. Statistically significant differences were found among mental health professionals based on gender difference, professional role, and level of experience. Women seemed more inclined to accept users' decision-making processes, including therapeutic risk-taking. Nurses seemed more cautious in considering the users able to "live beyond their illness". Professionals with fewer than 15 years of experience had more favorable attitudes and expectations than the more experienced respondents. Students had more optimistic expectations regarding recovery than nurses and social workers. Academic curriculum development for students and training courses for mental health professionals could further improve the homogeneity in attitudes and skills in the support of users' "unique" recovery processes.

Keywords Personal recovery · Mental health professionals · Mental illness · Recovery-oriented services

Introduction

"Recovery" has been defined in multiple ways and is still an evolving concept whose definitions and dimensions continue to intrigue researchers (Davidson et al. 2008; Giusti et al. 2015; Leamy et al. 2011; Lieberman et al. 2008; Macpherson et al. 2015; Roe et al. 2007). Personal recovery has been defined as "a way of living a satisfying, hopeful, and contributing life even with any limitations caused by illness" (Anthony 1993).

Italian mental health professionals have enthusiastically embraced this "new" vision, particularly in light of community psychiatry in our country; since the passage of Law 180, community psychiatry has stressed the importance of the inclusion and citizenship of people with mental illness and their rights to live satisfying lives. The study by Davidson et al. (2010), which had an Italian co-author, explicitly describes parallels between the ideas of Italian mental health reform and the current concept of "recovery" as discussed in the international mental health field (Becker and Fangerau 2017).

Although the term "recovery" does not have a direct translation in Italian, the word "recovery", borrowed from the English language, has become almost a "mantra" in mental health services in Italy.

While the recovery process for individuals is influenced by more than their contact with mental healthcare, such services will contribute to many people's recovery experience (Bird et al. 2014), and a poor recovery style and difficulties in engaging with services seem related to greater symptom severity and poorer social functioning (Rossi et al. 2017).

Bedregal et al. (2006) reported that mental health professionals had poor familiarity with the process of non-linearity and the role of hope in recovery, showing a greater emphasis on traditional approaches such as symptom management and compliance with treatment. Through their questionnaire survey, (Cleary and Dowling 2009) found that mental health professional staff directed less attention to encouraging healthy risk-taking with service users, despite the fact that

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therapeutic risk-taking and hope are essential in creating a care environment that promotes recovery.

A recent investigation (Le Boutillier et al. 2015) to identify what mental health professionals perceive as barriers and facilitators in providing recovery-oriented support suggested that efforts to transform services toward a recovery orientation would require a cultural whole-systems approach. The problem of reaching consensus about what is meant by recovery and producing a definition that is acceptable to service users, while being practical and achievable for clinicians and services, has yet to be resolved (Morrison et al. 2016).

What do mental health professionals mean by this term and its conceptualization, as in the recovery knowledge inventory (RKI) (Bedregal et al. 2006), a well-known assessment tool proposed by the scientific literature? How closely do mental health professionals adhere to the model proposed by such instrument?

To promote a real transformation of mental health services, there is a strong need to improve the level of sharing of the recovery paradigm among different mental health professionals, starting from their academic training. Research suggests that education can influence the development of more positive attitudes, and the education of health professionals is therefore crucial to the successful implementation of recovery-focused mental health services (Happell et al. 2015). Among the 22 Italian certified health professional profiles, "psychiatric rehabilitation technicians" represent the professionals who have undergone a 3-year academic curriculum to become skilled in properly administering psychosocial interventions. These technicians represent an innovative professional workforce in mental healthcare that has not yet been established outside Italy. In fact, the psychiatric rehabilitation technician (PRT) is a specific Italian mental-health academic and professional profile, created after the passage of Law 180 (Pingani et al. 2013; Roncone et al. 2016), to work in a psychiatric team. We were interested in comparing the attitudes regarding recovery of these students to those of experienced professionals.

The aims of this study were:

(i.) To examine the attitudes of Italian mental health professionals and students of the degree course in psychiatric rehabilitation regarding the model of personal recovery through a questionnaire survey using the RKI (Bedregal et al. 2006), and

(ii.) to examine the differences among mental health professionals and students in understanding the proposed recovery domains.

Methods

Study Participants and Procedure

From 2014 to 2015, the RKI (Bedregal et al. 2006) was administered to mental health workers recruited during meetings and conferences on mental health and psychiatric rehabilitation all over Italy (North, Central and South Italy) in which "recovery" was not the main topic. Students of the degree course in psychiatric rehabilitation techniques attending such meetings and conferences were also asked to fill in the RKI. Participants' main sociodemographic data (gender, age) and information regarding professional role, level of experience (years), and work setting were recorded.

Informed consent was obtained from all individual participants included in the study.

Instruments

We chose this instrument because it is quick and easy to administer and, in our opinion, consistent with the conceptual paradigm of personal recovery. The RKI (Bedregal et al. 2006), in its Italian version (Basso et al. 2016), was administered. Permission to use the RKI in our study was given by the instrument's authors (Bedregal et al. 2006). The scale consists of 20 statements on a 5-point Likert scale and assesses four different domains of understanding of recovery in mental health: (a) "*Roles and responsibilities in recovery*" (seven items; range score 7–35), regarding risk-taking, decision-making, and the various and respective roles and responsibilities of people in recovery and behavioral health providers (e.g., people with mental illness should not be burdened with the responsibilities of everyday life); (b) "*Non-linearity of the recovery process*" (six items; range score 6–30), regarding the role of illness and symptom management and the non-linear nature of recovery (e.g., recovery is characterized by a person making gradual steps forward without major steps back); (c) "*Roles of self-definition and peers in recovery*" (five items; range score 5–25), regarding a person's activities in defining an identity for him/herself and a life that goes beyond that of "mental patient", including the valuable roles that peers can play in this process (e.g., the pursuit of hobbies and leisure activities is important for recovery); and (d) "*Expectations regarding recovery*" (two items; range score 2–10), regarding expectations (e.g., not everyone is capable of actively participating in the recovery process). Each item is rated on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). 15 out of 20 items are reverse-coded (i.e., a score of one will be a five, a two will

be a four, a three will remain the same, a four will be a two, and a score of five will be a one). Item 10, "Only people who are clinically stable should be involved in making decisions about their care", was scored by attributing 5 to "strongly disagree".

Higher scores represent a greater orientation to the concept of recovery (cut-off scores are not reported in the literature). Cronbach's alpha relating to each of the subscales is reported by the authors (Bedregal et al. 2006) as follows: "Roles and responsibilities in recovery" (0.81), "Non-linearity of the recovery process" (0.70), "The role of self-determination and peers in recovery" (0.63) and "Expectations regarding recovery" (0.47).

To assess the recovery orientation, in our descriptive analysis, we recoded the RKI item scoring into dichotomous values (1–3 = 0, low recovery orientation; 4–5 = 1, high recovery orientation).

Analysis

Chi-squared tests and one-way analyses of variance (ANOVA) were conducted to examine differences in sociodemographic variables and domains of understanding of recovery in mental health, as measured by the RKI, based on gender difference, profession (psychiatrist, non-psychiatrist, and student), and level of experience (< 15 or > 15 years). Bonferroni's correction was performed for the three-group comparison. Statistical analyses were performed using SPSS 16.0 (SPSS Inc., Chicago, IL, USA).

Results

The total sample included 436 mental health professionals from mental health services and students of the degree course in psychiatric rehabilitation techniques. Three groups of mental health workers were identified: the first group consisted of psychiatrists (n = 100, 23% of the total sample, 50% women, mean age = 49.3, SD = 11.8), the second group of other mental health professionals (nurses, social workers, psychologists) (n = 249, 57% of the total sample, 82% women, mean age = 42.5, SD = 12), and the third group consisted of students of psychiatric rehabilitation techniques (n = 87, 20% of the total sample, 79% women; mean age = 24.6, SD = 5.6).

Approximately 57% of them were working in community mental health teams, and 20% were working in acute psychiatric inpatient wards (the total sample, excluding students: mean years of working in psychiatry 15.9, SD 10.8). In terms of experience, 30% had between 1 and 10 years of experience, 25% had between 11 and 20 years, and 44% had between 21 and 30 years or more.

Significant differences among professional groups [F(2.430) = 116.47; p = 0.000] were found for age, with higher mean values in the psychiatrist group (mean = 49.33, SD = 11.84), followed by the group of other mental health professionals (mean = 42.55, SD = 12.080), and the student group (mean = 24.63, SD = 5.6). Regarding gender ($\chi^2(2) = 37.75$, p = 0.000), there was a greater proportion of men in the psychiatrist group (50%) and women in the student group (79%, in a sample characterized by two-thirds women). The level of experience measured in years ($\chi^2(4) = 58.48$, p = 0.000) showed a greater proportion of subjects in the psychiatrist group (62.6%) reporting a level of experience > 15 years.

The majority of participants had no formal training in personal recovery principles, and those with exposure to this concept had gained their knowledge through informal methods rather than through structured programs.

The study was well accepted, since it was anonymous, and the self-filled questionnaire and data collection process were short (approximately 15 min); on average, < 20% of participants failed to return the questionnaire and their data form.

Recovery Knowledge Inventory: Group Differences for Total Score and Component Scores

Recovery orientation was reported as "low recovery orientation" and "high recovery orientation".

The majority of respondents (more than 80%) recognized the personal identity of users, the importance of hobbies and leisure activities, the support of people suffering of mental illness, and the importance of the concept of recovery to all phases of treatment. Approximately 70% of respondents agreed on users' involvement in their treatment, setting goals, and decision making, even if users were not clinically stable.

A lower, almost contradictory attitude toward recovery was shown in terms of the need for symptom reduction, adherence to treatment, and low expectations of a non-linearity of the recovery process, whereas < 30% of responders agreed with the personal perspective regarding users, a perspective far from the traditional clinical model.

No statistically significant differences were found among the three groups in the total mean RKI score (psychiatrists mean score 66.43, SD 8.9; other mental health professionals, 64.78, SD 7.9; students 64.71, SD 6.8), showing a good global attitude.

Comparing the mean scores obtained from the four components of RKI based on *gender difference*, women obtained the highest mean value in the component "*Roles and responsibilities in recovery*" [men 4.63, SD 0.85; women 4.81, SD 0.76; F(1.432) = 3.79; p = 0.050]. This result would suggest that professional women had more favorable attitudes about

the users' decision making and their risk-taking in planning their lives compared to men. Statistically significant differences occurred among *the three identified groups* (psychiatrists, non-psychiatrists, students) in the component "*Expectations regarding recovery*", with the highest mean value for students compared to non-psychiatrists [students 3.16, SD 0.85; non-psychiatrists 2.76, SD 0.81; F(2.433) = 6.942; p = 0.001; post hoc Bonferroni mean difference − 0.4050; p = 0.001].

Statistically significant differences were found among the different *main professional roles and students*, nurses showing statistically significantly lower scores in the "*Role of self-definition and peers in recovery*" (3.98, SD 0.48) compared to social workers (4.26, SD 0.52; post hoc Bonferroni mean difference − 0.2774; p = 0.031) and psychiatrists (4.25, SD 0.51; post hoc Bonferroni mean difference − 0.2774; p = 0.007). Students showed statistically significantly higher scores (n = 87, 3.18, SD 0.83) in the domain of "*Expectations regarding recovery*" compared to nurses (2.59, SD 0.8; post hoc Bonferroni mean difference − 0.5930; p = 0.000) and social workers (2.72, SD 0.90; post hoc Bonferroni mean difference − 0.4616; p = 0.020).

Statistically significant differences were also found based on the *level of experience* in the dimension of "*Roles and responsibilities in recovery*" (professionals < 15 years experience, n = 169; 3.47, SD 0.52; professionals > 15 years experience, n = 183; 3.34, SD 0.62 [F(1.350) = 4.438; p = 0.036], and "*Expectations regarding recovery*" (professionals < 15 years experience, 2.92, SD 0.85; professionals > 15 years experience, 2.68, SD 0.84 [F(1.350) = 7.175; p = 0.008]. Less-experienced staff seem to have more favorable attitudes and expectations than more-experienced respondents about the users' roles and responsibilities in their recovery process.

Discussion

In the Italian psychiatric scenario, in which the values and recovery-oriented practices were largely suggested by Law 180, we were interested in verifying how closely mental health professionals adhered to the model proposed by the RKI, an internationally recognized tool to assess "recovery". Furthermore, we were interested in assessing the recovery attitudes of the students studying psychiatric rehabilitation techniques, a degree course devoted to training professionals in the use of psychosocial strategies, as we consider these students important future agents of change.

Our study can be considered innovative, as it considers different mental health professional groups, such as psychiatrists, psychologists/psychotherapists, nurses, social workers, and students of psychiatric rehabilitation techniques, from the perspective of the homogeneity of their recovery vision.

In our descriptive analysis, our sample seemed to agree on the principles of users' personal identity, their treatment involvement based on their goals and the valid support they received from persons affected by mental disorders, but participants still demonstrated the assumption that psychopathological stability is an important factor for users' personal recovery.

No statistically significant differences were found among the three groups in total mean RKI score, showing a good global attitude. In the 40 years since the introduction of Law 180, in 1978, which abolished psychiatric hospitals and sought to integrate psychiatric care within the social context of the community, Italian psychiatrists, mental health workers, and students of mental health have come to reflect a recovery-oriented biopsychosocial perspective in their attitudes and in their work. Moreover, the model of the RKI accurately assesses their attitudes despite its supposed difficulty in perfectly fitting the cultural context, as seen in other different countries (Hungerford et al. 2015).

In *gender difference*, there was a statistically significant difference in the "*Roles and responsibilities in recovery*" dimension, with women obtaining the highest mean value in this component. This finding suggests that male respondents were less in favor of accepting "therapeutic risk" and user responsibility in their decision-making. Indeed, risk is commonly regarded as something negative and to be avoided and is frequently defined in terms of "physical harm to self and others" (Ryan 2001). In contrast, there is a dearth of literature promoting therapeutic risk-taking, otherwise referred to as a positive factor (Stickley and Felton 2006). In our sample, more than two-thirds of professionals were women, and the higher percentage of male respondents were psychiatrists. The simple explanation of this finding would depict Italian psychiatrists as overprotective and/or paternalistic, where paternalism could be interpreted as "always acting in the user's best interest". Indeed, despite the normative trend toward reciprocity in psychiatry throughout the Western world, paternalism also appears to be the dominant perspective in a Swedish sample of psychiatric staff members (Pelto-Piri et al. 2013). Nonetheless, the attitude of Italian psychiatrists in our sample may also have a different explanation, since it could be related to medical professional liability, a highly relevant issue in modern-day Italy. The Italian court's recent judgments on sentences such as manslaughter have reiterated psychiatrists' culpability because of their obligations of custody and high surveillance of users in their care settings, prompting a more cautious attitude among mental health professionals (Terranova and Rocca 2016; Terranova and Sartore 2013).

Statistically significant differences were found between *respondents with fewer than 15 years* and respondents with

more than 15 years of experience in mental health in the "*Expectations regarding recovery*" component. Less-experienced staff had more favorable attitudes than more-experienced respondents about expectations regarding recovery. This favorable attitude was also shown by the young population of students in psychiatric rehabilitation degree courses, reflecting very positively on this group. In fact, it seems that when professionals have low expectations for service users, they delay the recovery journey and, in fact, encourage learned helplessness (Roberts and Wolfson 2004). An analogous previous study (Cleary and Dowling 2009) found that less-experienced respondents had a higher mean score for the "*Non-linearity of the recovery process*" component than experienced respondents; the results of the present study, in which younger mental health workers and students seem to show a higher cognitive openness and flexibility than their more-experienced colleagues, thus confirm the results of Cleary and Dowling (2009).

Recovery education for medical students, psychiatry residents, psychologists and social workers, as well as rehabilitation students, pre/post-doctoral students and professionals, within a variety of academic settings should be implemented and integrated into existing, accredited academic programs and curricula. The curricula should include recovery-oriented practice principles and interventions and could be improved not only through the assessment of interviews and questionnaires but through evaluation of practitioners' practical skills in involving users in the treatment and in the planning and use of mental health services.

Our study showed a good global orientation toward recovery in our mental professionals and students, although they have still some difficulty in accepting "non-linearity" and their users' well-being "beyond" treatment adherence. There is a need for a recovery paradigm to improve staff understanding of recovery-oriented practice in order to achieve a better degree of agreement and sharing among different mental health professionals and to improve the organization of mental health services. Moreover, after the recent closure of Italian forensic hospitals, a new recovery-oriented rehabilitation approach has also been recommended also for persons with mental disorders who have committed a criminal offence but lack criminal responsibility and are deemed as socially dangerous (Casacchia et al. 2015).

Despite some limitations at the organizational level (Mezzina 2018), the Italian community-based system of care can represent a fertile breeding ground for further improvements of the "recovery paradigm" underlying our existing practices, oriented toward reinstating full citizenship to people with mental health disorders. Academic curriculum development for students and training courses for mental health professionals could contribute to promoting improved homogeneity in attitudes and skills in the support of users' "unique" recovery processes.

Our study presents three main methodological limitations. First, the RKI instrument, which is not completely free of cultural bias, assesses the degree of orientation and the level of knowledge regarding a conceptual paradigm of personal recovery but does not define the skills that are useful in clinical practice. Second, the "other health professionals" group includes different types of practitioners with different training backgrounds. Third, the results cannot be generalized, since the attitudes regarding the concept of recovery of Italian mental health professionals are related to a limited number of professionals in this study.

Conclusions

To improve the organization of mental health services, a shared theoretical, practical, and culturally appropriate model translating the principles of the recovery process, starting from academic curriculum development, is needed among different mental health professionals.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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