Recovery Outcome Measures: Is There a Place for Culture, Attitudes, and Faith?

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PURPOSE: Utilization of the Recovery Knowledge Inventory (RKI) and Recovery Attitudes Questionnaire (RAQ) in southeastern Australia raised questions about the RAQ, including links between attitudes, faith, and culture in supporting the recovery journey. These questions are particularly important when considered in the context of people with mental illness who live in secular multicultural societies.
CONCLUSIONS: This paper discusses the cultural appropriateness of the RAQ in Australian settings, and identifies the need to develop rigorous, inclusive recovery outcome measures.
PRACTICE IMPLICATIONS: It is important to identify what best motivates people in their recovery journey, and to find a way to harness these motivating factors to achieve the best possible outcomes.

In Western health settings, "recovery" for people with a mental illness is defined as a consumer-centered approach that is framed by the principles of self-determination and collaboration, underpinned by the notions of hope and optimism (Bennetts, Cross, & Bloomer, 2011; Corrigan et al., 2012; Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009; Piat & Lal, 2012; Slade, Adams, & O'Hagan, 2012). Recovery approaches to health care have been implemented in countries such as Australia, Canada, New Zealand, the United Kingdom, and the United States (Cleary, Walter, & Hungerford, 2014; Hungerford & Kench, 2013). Such widespread implementation has given rise to the need for validated tools to measure the outcomes of these recovery models (Cleary & Dowling, 2009; Meehan & Glover, 2009; Wilrycx, Croon, van den Broek, & van Nieuwenhuizen, 2012).

One such tool, developed in the United States, is the Recovery Knowledge Inventory (RKI), a self-administered questionnaire that measures the knowledge of recovery achieved by health professionals who deliver consumer-centered mental health services (Bedregal, O'Connell, & Davidson, 2006). Another self-administered questionnaire, the Recovery Attitudes Questionnaire (RAQ), was also developed in the United States, when it was found that the adoption of recovery-oriented principles and practices by mental health professionals was influenced by their attitudes and hopefulness toward the possibility of recovery for people with a mental illness (Borkin et al., 2000). Findings from the use of these tools in cultural contexts other than the United States, however, have been mixed. For example, Wilrycx et al. (2012) tested the fit of the RKI and RAQ for a Dutch population and found the tools required changes to support cultural fit.

This paper reports on research undertaken in Australia to further test the RKI and RAQ, with findings used to ponder the question: Are these tools culturally appropriate in the Australian context? How appropriate is it to link recovery, attitudes, and faith? More broadly, how do cultural differences challenge or extend notions of attitudes toward

recovery? Answers to these questions are important for consumers who seek to apply the principles of recovery to support people with mental illness, and also for those briefed to measure the effectiveness of these approaches.

Background

In Australia, the implementation of recovery-oriented mental health services has occurred in states and territories across the country in response to national strategic direction set by the federal government, in response to international trends to support consumer-centered approaches to health care (e.g., Australian Health Ministers Advisory Council, 2013; Department of Health (UK), 2001; Mental Health Commission of Canada, 2009; New Zealand Mental Health Commission, 2001; O'Hagan, 2004; U.S. Department of Health and Human Services, 2004). Recovery-oriented services focus on promoting collaboration, participation, and partnerships between service providers and consumers, and enabling self-determination for consumers (e.g., Hungerford, 2014; Slade et al., 2012). Likewise, recovery models or approaches enable a person with mental health issues to live a meaningful and contributing life in the community of his or her choice, and support them in their "journey of transformation" (Australian Capital Territory Health, 2003, p. 1).

The Australian Capital Territory (ACT), home to Australia's national government and populated by some 350,000 people, is serviced by a range of publicly funded bed-based and community-located mental health services. Implementation of recovery-oriented services commenced in 2003, and involved a lengthy process of consultation with a wide range of stakeholders, changes to policy and procedure to ensure consistency with the strategic direction set by the national government, and support for mental health professionals to make the transition to delivering recovery-oriented services (Australian Capital Territory Health, 2004, 2006; Australian Health Ministers, 2009; Fanning, Rosen, & Hoskin, 2006).

Evaluation of the outcomes of the implementation of recovery-oriented services in the case study context commenced in 2010. Using a case study framework, the evaluation aimed to identify factors that challenged the effectiveness of the implementation of recovery-oriented services, and consider solutions to these challenges. The focus of this paper is the mental health professionals' knowledge of and attitudes to recovery, and the impact of cultural understandings on this knowledge and attitudes.

Methods

Case studies provide a useful means of enabling the development of theory through a process of analytic generalization, where results of the case study analysis are compared to and used to extend previously developed theory (Yin, 2009).

The current study is part of a single-case embedded study comprising multiple units of analysis, with findings from each of these units used to build a cumulative picture (Hungerford & Richardson, 2013). The unit of analysis that features in this paper involved investigation of knowledge and attitudes of mental health professionals involved in the operationalization of recovery using the RKI and RAQ. The aim of this aspect of the case study was to test the emerging theory related to the usefulness of the RKI in Australia, and commence the development of theory to inform the use of the RAQ in this country.

With the implementation of recovery-oriented services in the ACT, training in recovery was mandated for all health professionals working in the public mental health service on permanent full-time, part-time, and temporary contracts, with health professionals on casual contracts excluded. The health disciplines involved were medicine, nursing, occupational therapy, psychology, and social work. The two single days of training were held 4 months apart, and were supplemented by ongoing professional development in the form of fortnightly supervised case reviews, provided over a period of 6 months. The RKI and RAQ were used retrospectively 6 months after the second single day of training. Participants were also invited to provide narrative comments at the end of the questionnaires.

Findings derived from using the RKI were compared with those produced by a previous study using the RKI in a different Australian jurisdiction. The previous study was located in Queensland, some 1,200 km north of the ACT, and found that the RKI was suitable for use by the sample population (Meehan & Glover, 2009). Findings produced from using the RAQ were compared with those identified in the broader research literature as there is no evidence that the RAQ has been used previously in Australia.

Measures

The RKI has 20 items that cover four domains of knowledge: roles and responsibilities in recovery (7 items); nonlinearity of the recovery process (6 items); the roles of self-definition and peers in recovery (5 items); and expectations regarding recovery (2 items). The RKI items are rated on a 5-point Likert scale, with answer categories ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The developers of the scale report reliability coefficients (α) of 0.81, 0.70, 0.63, and 0.47 for each of the four underlying domains. In the present study, the alpha values obtained were 0.71, 0.77, 0.51, and 0.45 for the four domains and a coefficient of 0.78 for the total scale score.

The RAQ-7 has seven items and includes two domains: recovery is possible and needs faith (factor 1); and recovery is difficult and differs among people (factor 2). Items were rated using a 5-point Likert scale, ranging from 1 (*strongly agree*) to

5 (*strongly disagree*), with lower scores indicating a more positive attitude toward the idea of recovery. The developers of the scale reported reliability coefficients of 0.674 for the RAQ-7: 0.609 for factor 1 and 0.619 for factor 2. For the present study, the alpha values obtained were 0.737 for the RAQ-7, and 0.715 and 0.666 for the two factors. Although this can be considered adequate for the purposes of research, a closer examination of the questionnaire item—total statistics—indicated that the overall alpha would increase to 0.807 if two items were removed. These items were "To recover requires faith" and "Stigma associated with mental illness can slow down the recovery process."

Ethical Issues

The study received approval from two human research ethics committees, one attached to the local university (Project No. 10-127) and the other attached to the mental health service organization (ETH.10.324). Managers of the publicly funded mental health service also gave their full support to the conduct of the research. Participants—all staff of the mental health service—were recruited by way of e-mail advertisement and flyer promotion. Information about the research, including an explanation of each person's right not to participate or to withdraw after making the decision to participate, was made available to each potential participant. Consent was obtained from the participants prior to participation.

Data Analysis

To test the effectiveness of the RKI, a series of single sample *t* tests was conducted to compare the post-training data derived from the ACT context, with the post-training data presented by Meehan and Glover (2009). The post-training data from the ACT context were initially compared against Meehan and Glover's post-training control group (i.e., those participants who did not receive any recovery training). Another set of single sample *t* tests was also run to compare the post-training data from the ACT context with Meehan and Glover's post-training data.

Results

In total, 98 participants (56% of all staff) attended the first single day of training and 75 (43% of all staff) on the second single day of training. Not all those who attended the first day of training attended the second day, and not all those who attended the second day of training had attended the first day. Reasons for the inconsistent attendance included leave and issues related to the implementation of recovery, with anecdotal reports suggesting that morale was low. A total of 120 people were e-mailed surveys post-training. Completed RKIs and RAQs were returned by 58 participants (48%).

RKI Comparisons

An examination of the data demonstrated that participants obtained the highest mean (*SD*) score of 4.19 (.44) on domain 1, "roles and responsibilities in Recovery." The second highest score was 4.08 (.47) on domain 3, "the roles of self-definition and peers in Recovery." The participants' third highest mean score was 3.23 (.95) on domain 4, "expectations regarding Recovery." The participants' lowest mean score of 2.94 (.64) was on domain 2, "non-linearity of the Recovery process."

Five single sample *t* tests were used to compare the average RKI domain scores of participants who had recently undertaken a recovery training course with the average RKI domain scores of a control group from another study who had not been given a recovery training course (Meehan & Glover, 2009). The results are outlined in Table 1.

Another five single sample *t* tests were used to compare the average RKI domain scores of participants who had recently undertaken a recovery training course with the average RKI domain scores of a group from another study who had also received a recovery training course (Meehan & Glover, 2009). The results are outlined in Table 2.

RAQ Factor Analysis

Two items, "To recover requires faith" and "Stigma associated with mental illness can slow down the recovery process," within the RA7 did not fit particularly well within the two

Table 1. Comparison of Means and Standard Deviations Between Current Post-Training Group and Comparison Control Group

Variable	Control comparison		Current post-training				95% CI		Cohen's
	M	*SD*	*M*	*SD*	*T*(57)	*p*	LL	UL	*d*
(1) Roles and responsibilities	3.62	.68	4.19	.44	8.99	< .001	.43	.68	1.19
(2) Nonlinearity of the recovery process	2.59	.70	2.94	.64	3.95	< .001	.18	.56	0.52
(3) Role of self-definition and peers in recovery	3.80	.51	4.08	.47	3.63	.001	.11	.39	0.49
(4) Expectations regarding recovery	2.81	.88	3.23	.95	2.71	.009	.09	.61	0.36
Total RKI	3.21	.88	3.69	.40	8.71	< .001	.37	.59	1.20

LL, lower limit; RKI, Recovery Knowledge Inventory; UL, upper limit.

Table 2. Comparison of Means and Standard Deviations Between Current Post-Training Group and Comparison Post-Training Group

Variable	Post-training comparison		Current post-training		T(57)	p	95% CI		Cohen's d
	M	SD	M	SD			LL	UL	
(1) Roles and responsibilities	4.19	.59	4.19	.44	−0.19	.847	−.14	.11	0.03
(2) Nonlinearity of the recovery process	3.49	.62	2.94	.64	−5.68	< .001	−.72	−.34	0.71
(3) Role of self-definition and peers in recovery	4.22	.47	4.08	.47	−2.47	.017	−.31	−.03	0.33
(4) Expectations regarding recovery	3.70	.83	3.23	.95	−4.17	< .001	−.80	−.28	0.56
Total RKI	3.89	.49	3.69	.40	8.99	< .001	.43	.68	0.50

LL, lower limit; RKI, Recovery Knowledge Inventory; UL, upper limit.

factors. As such, it was decided to investigate each item individually (Table 3). This shows that the statement "To recover requires faith" is the least agreed upon statement within the RAQ-7. The statement "Stigma associated with mental illness can slow down the recovery process" is supported by the participants, but it is not as strongly supported as its fellow items "People in recovery sometimes have setbacks" and "People differ in the way they recover from a mental illness."

Discussion

Findings from the use of the RKI in the case study context suggest equivalence with the results of the study undertaken by Meehan and Glover (2009) in Queensland. These findings confirmed the suitability of the RKI for use in Australia.

With regard to the RAQ, however, findings suggest the need for further research to confirm suitability or adaptation for Australian use. For example, and as already noted, the item "To recover requires faith" did not fit well within the two factors. In addition, this item was found to be the least agreed upon statement within the RAQ-7. Consequently, the researchers identified these issues to be of interest, especially when considered in light of a narrative comment provided by one participant in response to this item: rather than providing an answer using the Likert scale provided, the participant wrote "Faith in what?" [Participant 43].

It is important to note that the RAQ was developed in the United States, where notions of faith and religious freedom have strong links to the nation's history (Berry & York, 2011). Contemporary Australia's colonial roots, however, are quite

different—for example, Australia's first European peoples were a mix of British convicts and free settlers in search of a better life and "fair go" (Doyle, 2011). The ofttimes overwhelming challenges faced by the British settlers in the harsh Australian environment gave rise to the archetype now known as the "Aussie battler," self-reliant and fatalistic (Whitman, 2013). Today, notions of antiauthoritarianism, egalitarianism, self-reliance, and belief in fate rather than a providential higher power feature large in the Australian psyche (Turner, 2002).

This history has also played a role in the secularization of Australia's society, with the most recent national census suggesting that one in five Australians have no religion, while for those who do report a religious affiliation, only 15% of men and 22% of women aged 18 years and above actively participate in a religious or spiritual group (Australian Bureau of Statistics, 2013). Such demographics raise questions about the appropriateness, in the Australian context, of linking the notions of recovery, attitudes, and faith: How are positive attitudes toward a practice expressed by health professionals in the secular Australian culture? What is the relationship between culture and notions of attitudes and faith?

Prior to the rise of cultural studies as an intellectual movement (Hall, 1980), the meaning of "culture" was relatively narrow—for example, people equated culture with the arts; or alternatively, the quite distinct even exotic ways of life expressed by different ethnic groups. Today, however, the term culture has multiple meanings. Some use the term as a subcultural descriptor, such as "cultures of care" or "cultures of mental health nursing practice" (Lakeman, 2013). Alterna-

Table 3. Descriptive Statistics for the RAQ-7

Domain	Item	M	SD	Min	Max
1. Recovery is possible and needs faith	2. To recover requires faith	2.80	.94	1	5
	4. Recovery can occur even if symptoms of mental illness persist	1.81	.74	1	3
	5. Recovering from mental illness is possible no matter what you think may cause it	1.88	.82	1	4
	6. All people with serious mental illnesses can strive for recovery	1.80	.80	1	4
2. Recovery is difficult and differs among people	1. People in recovery sometimes have setbacks	1.64	.49	1	2
	3. Stigma associated with mental illness can slow down the recovery process	1.67	.69	1	4
	7. People differ in the way they recover from a mental illness	1.52	.50	1	2

tively, Doyle and Hungerford (in press) identified links between notions of culture and religion (D'Souza, 2013), language (Nishita & Browne, 2013), country (Gelter & Siems, 2013), gender (Lumby & Azaola, 2013), and family (Mattaini, 1996). Others again equate culture to social adhesion and cohesion (e.g., Seiler, 2013). Broadly speaking, then, "culture" can be defined in postmodern terms as the accepted patterns of knowledge, beliefs, attitudes, and behaviors by which a group of people live, including the shared history, traditions, values, attitudes, goals, practices, and ways of seeing the world, that characterize that group of people (Bass, Eaton, Abramowitz, & Sartorius, 2012; Jahoda, 2012; Williams, 1983). Each person's sense of "right" is determined by the culture(s) to which he belongs; and this in turn leads to that person's adherence to the norms of the society in which he is located (Griswold, 2013). When the culture of a group of people provides the means by which the group makes sense of the world, then it becomes necessary to define key concepts according to that culture to facilitate understanding and support communication. Such definitions include health-related concepts such as "attitudes" and "faith."

The Cultural Construction of "Attitudes"

As already noted, the RAQ is used to measure the attitudes of a range of stakeholder groups, including consumers, health professionals, family members, or significant others, together with community members, in relation to mental health recovery (Borkin et al., 2000; Wilrycx et al., 2012). When developing their instrument, however, Borkin et al. (2000) provided no definition of the term "attitudes," suggesting they viewed the term's meaning as self-evident—that is, universal, understood in the same way across a range of cultures and therefore requiring no explanation. Moreover, although Borkin et al. provided no definition, they went on to make a connection between the term and a "sense of self" (Borkin et al., 2000, p. 96). This connection links "attitudes" to the notion of individualism—for example, individualistic cultures tend to privilege notions of the individual or "self" over those of "group think" or the common good (Bailey & Dua, 1999). This points to a quite specific cultural construction of the term "attitude" by Borkin et al.—that is, a construction that is not necessarily inclusive of multicultural or even collectivist worldviews.

Others have defined "attitude" as a complex psychological tendency that involves viewing an object or subject with favor or disfavor—with positivity or negativity (Eagly & Chaiken, 2007). This tendency involves a degree of judgment or evaluation on the part of the person, whether overt/conscious or covert/unconscious, with this judgment a product of the person's background, education, and experiences, and also feelings or emotions, thoughts or beliefs, and behaviors (Happell & Cadeyrn, 2013). Such a definition of the term "attitude,"

then, is likewise culturally constrained, linked as it is to notions of the judgment, feelings, and the beliefs of a person or group of people. To exemplify, the judgment exercised by a mental health practitioner will be influenced by a number of factors, including their personal and cultural background and values, as well as their levels of education, professional experience, the team within which they are working, and clinical context (Hungerford, Hodgson, & Marks, 2013).

Consequently, the influence of culture on the meaning-making of notions such as attitudes, judgments, feelings, and beliefs raises questions around the appropriateness of linking attitudes (as well as judgments and beliefs) and recovery without first providing definitions of the terms. For example, and from a more multicultural and even inclusive point of view, could more appropriate links be made between recovery and notions of tolerance or acceptance of difference? Questions such as this suggest the need for more research to refine the RAQ for cross-cultural applicability.

The Cultural Construction of "Faith"

As with the notion of attitudes, "faith" is a concept that has diverse meanings, dependent upon the culture, context, and even the setting in which it is used (Pelechova, Wiscarson, & Tracy, 2012). For example, some groups may use the term informally—such as "have faith in the system"—to suggest a connection between notions of faith and trust (Maynard, 2013; Renzaho, Polonsky, McQuilten, & Waters, 2013). Dyess (2011), however, notes that faith is more often used in the disciplines of philosophy and/or theology, where the term is connected to the way in which a person or group finds meaning in their existence or makes sense of life's experiences. At the same time, notions of faith and belief are also about meaning-making—which, as explained above, has strong links to culture (Brown, 2008).

The connection between the making of meaning and the notions of faith and culture suggests one reason why some commentators say that, since science has replaced religion in many Western or secular cultures, faith has located itself within the science-based discourses (Koenig, 2004). For example, in the Western health context, faith has been linked to the treatments or interventions developed by researchers and implemented by practitioners—including evidence-based interventions (Newlin, Dyess, Allard, Chase, & D'Eramo Melkus, 2012; Salsman, Garcia, Lai, & Cella, 2012). Of particular note are the connections that have been made between faith and the placebo, the latter of which has become a predictor of improvement in health status for those receiving psychotherapy or pharmacotherapy (Mommaerts & Devroey, 2012; Trimmer, Marshall, Fromhage, McNamara, & Houston, 2013). Similarly, many mental health professionals believe or "have faith" that science has or will one day unlock what is still not known about mental illness, through the

study of genetics or neuroscience (Insel & Wang, 2010). A quandary is raised, however, when this stance is compared to that taken by authors of the *Diagnostic and Statistical Manual of Mental Disorders* who, over the years, have been unable to deduce specific cause-and-effect explanations for complex diagnoses such as schizophrenia and instead rely on consensus to identify a condition and its effect (Kapur, Phillips, & Insel, 2012). On the one hand, then, mental health professionals have "faith" that science will provide treatments or cures for disability or disease. On the other hand, they rely on a consensus approach to intervening (Petry et al., 2014).

This situation explains why some commentators also argue that "faith" is central to the hierarchical structure of authority in health service organizations, supporting as it does health professionals to undertake often unpalatable actions in the short term, with a view to achieving long-term improvements in the person's health (la Cour, 2008). For example, in the field of mental health, coercive treatments may sometimes be administered by health professionals who have faith that such treatments do or will work, or that the person who is prescribing the treatment is competent to do so (Vuckovich & Artinian, 2005). In such settings, having faith in the health system itself is justified and maintained by biomedical discourses, with evidence-based practice taking on common sense status in the Western health context (Lakeman, 2013). Indeed, the authors of this paper would go so far as to suggest that most mainstream health professionals have faith in evidence-based interventions—relying as they do on the acceptance of a particular treatment by experts and/or peers, the esteem with which prescribing medical practitioners are held, together with the authority of the systems or structures of management set up by a service organization to support the treatment's use. Notions of faith in this context, then, have evolved to accommodate the scientific paradigm, with communities of like-minded people developing beliefs and practices, teaching these beliefs and practices to novices and those around them, reinforcing them as the required standards in the communities, and losing sight of the fact that these beliefs and practices have been constructed over time.

Reasons for this process of accommodation include the tendency in people to seek out certainty and stability (Burström, Brännström, Boman, & Strandberg, 2012). Common sense notions of "this is just the way things are" serve to alleviate the need to question the ordinary. Instead, widely accepted notions allow people—including people with mental illness—to participate with ease in day-to-day life. It is important, then, that health professionals, including researchers, are aware of the cultural constructions of even the most commonplace when intervening or interacting. As noted by Holland (2011), people with mental health issues will most often look to those closest to them—to their communities and culture; and the attitudes, values, goals, and

practices of these communities and cultures—for explanations of their distress and solutions to this distress. The explanation or solutions provided by health professionals to help people make sense of their world, then, must be culturally appropriate. Likewise, the ways and means of measuring the outcomes of these explanations or solutions must be culturally appropriate.

Of course, it is also important to recognize that faith is an interpretive framework that predisposes individual behavior rather than determines it (Galdas et al., 2012). Individuals can be viewed as an "agent," influenced by the traditions and practices of a particular faith and culture, but also the dynamics of broader social and structural contexts (Lynam, Browne, Kirkham, & Anderson, 2007). Faith can play a central role in a person's perception and acceptance of his condition, and also the extent to which it could be managed through the adoption of lifestyle changes (Galdas et al., 2012). At the same time, however, the cultural and also evolving construction of faith raises similar questions to those posed above in relation to attitudes and beliefs. Such qualities suggest the need to define the terms "attitude(s)," "recovery," and also "faith" when linking them—or, alternatively, defining and defending the use of alternative terms such as tolerance and acceptance. This need is particularly important for those who seek to refine the RAQ, to support cross-cultural applicability.

Practical Implications

Mental health professionals, researchers, and also consumer advocates must think critically about any approach or solution that proposes a "one size fits all" approach in multicultural societies. This includes approaches to measuring the outcomes of the implementation of recovery-oriented services. The "common sense" of what is the "right" way of being or doing will always be culturally informed—and this will inevitably include understandings of the "right" way to implement and also measure the outcomes of recovery-oriented services. More specifically related to the findings of this research, there is an identified need for researchers to adapt and test the RAQ in an Australian context, including populations for a range of cultural groups. This will be the focus of future research.

Additionally, and in a multicultural landscape, mental health professionals must be aware of and open to ideas of difference, and explore ways of including rather than excluding those who see or interpret the world through diverse lenses. Varied understandings of the notions of "Recovery," "attitudes," and "faith" suggest the need for flexibility and acceptance. What is perhaps most important for mental health professionals across the disciplines is to identify what it is that motivates a person or carries them forward—whether this be faith in a higher being, a community of support, or a

health system. This motivation is an essential component of mental health recovery.

Conclusion

This paper reported on research undertaken in Australia to test the RKI and RAQ. It was found that the RKI was suitable for use in the Australian context; however, questions were raised over the cultural appropriateness of the RAQ for use in a secular and multicultural context. Notions of attitude and faith were considered through a cultural lens, with both terms identified as cultural constructions in need of definition according to the context in which they are located. Finally, recommendations were made to adapt the RAQ to ensure cultural appropriateness, with further research required to support this process.

Acknowledgments

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