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Effect of Training Program Based on Wellness Recovery Action Plan on Knowledge and Attitude of Psychosocial Workers toward Recovery Process.

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بسم الله الرحمن الرحيم

" وَفِي أَنْفُسِكُمْ أَفَلا تُبْصِرُونَ "

صدق الله العظيم

(سورة الذاريات آيتى 21)

Dedication

I dedicate this work first of all to my dear parents, sisters, brothers who encouraged me across my life. Special thanks and admiration to my sweet half, my wife and my beloved children (Ahmad, Omran, Sama) for their patience, courage and endless support.

Mohammed Omran Abu Shawish.

Date: 20/6/2012

Declaration

I certify that this thesis is submitted for the degree of master is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for higher degree to any other university or institution.

Signed

Mohammed Omran Abu Shawish.

Date: 20/6/2012

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I would like to express my great thanks and gratitude to all people who courage and contribute to the success of this endeavor towards obtaining my master degree.

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Abstract

Recovery is perhaps the most recent and talked about paradigm in the mental health field, Anthony defined recovery as "a deeply personal, unique process of changing ones attitudes values feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness".

The current study addresses community mental health care providers' knowledge, attitudes before and after training program, and competencies regarding recovery from mental illness. A total of 47 participants completed pre and post test and key member attend focus group that assessed recovery constructs and provider variables.
The result of gender distribution show that the male percentages 47.6 while the female percentage is 57.7%. and Age range between 23 and 45 with mean 30,7 years. The most academic qualification hold was Bachelor's Degree (66%).

Descriptive statistics and Qualitative analysis indicated that providers held positive attitudes toward recovery after training program, were start with a mean score of Recovery Attitude Questions 51.787 (SD = 4.318). This increased to 62.361 (SD = 5.264) post program, were moderately competent in implementing recovery principles, and earns enough knowledge of recovery, were *pre- training mean of Recovery Knowledge Question (m = 62.978), post- intervention (m =72.914), mean differences was (-9.936) and t value was (-12.163), Correlation analyses indicated that there was no significant relationship between provider knowledge and attitudes toward recovery and sociodemographic characteristics.*

The studies conclude that with minimal education and training we can improve the knowledge about recovery process among community mental health providers and also make their attitude positive regarding it.

Key words: Recovery, Wellness Recovery Action Plan, Training Program

ملخص الدراسة

إن هذه الدراسة تعتبر محاولة لتسليط الضوء علي مفهوم جديد من مفاهيم العمل في مجال الصحة النفسية وهو مفهوم التعافي والذي اصبح هو الاتجاه الحديث في التعامل مع المرض النفسي وهو مفهوم شمولي يعبر عن التجربة الشخصية العميقة والعملية الفريدة في تغيير الاتجاه نحو المرض النفسي وسبل التغلب عليه مما يجعل المريض يعيش حياة سعيدة نسبيا حتي في وجود الاعراض والتحديات التي تفرضها عليه طبيعة مرضه.

الدراسة الحالية تستهدف الكشف عن الاتجاهات والمعرفة لدي الاخصائيين النفسيين والاجتماعيين في الادارة العامة للصحة النفسية نحوي عملية التعافي واختبار فعالية برنامج تدريبي مبني علي خطة الدمج والتعافي (WRAP)، تم بناءه من قبل الباحث علي المعرفة والاتجاه لدي الاخصائيين النفسيين والاجتماعيين نحو عملية التعافي.

استخدم الباحث المنهج الكمي والنوعي في الدراسة من خلال بناء اداة (استبيان لقياس مستوي المعرفي والاتجاه لدي المهنيين قبل وبعد البرنامج) ، كما تم عمل مجموعات نقاش (مجموعة بؤرية) شملت المهنيين الاساسيين في المراكز ، اشتملت عينة الدراسة علي 47 اخصائي نفسي واجتماعي وهم جميع الاخصائيين العاملين في الادارة العامة للصحة النفسية بمعدل 47.6% ذكور و 57.7% اناث، بمتوسط عمر 30.7 سنة، وكان معظم الاخصائيين حاصلين علي درجة البكالوريوس.

اسفرت نتائج الدراسة عن وجود فروق ذات دلالة احصائية بين الاختبار القبلي والبعدي لصالح البعدي في مستوي المعرفة وطبيعة الاتجاه نحو عملية التعافي حيث كان متوسط نتائج تحليل الاسئلة التي تقيس الاتجاه نحو عملية التعافي قبل البرنامج التدريبي (م = 51.787) ، وانحراف معياري (ع = 4.318) ارتفع بعد البرنامج ليصل الي (م = 62.361) ، وانحراف معياري (ع = 5.264) ، كما ان نتائج التحليل للاسئلة التي تقيس مستوي المعرفة اظهر ارتفاعا في المتوسط الحسابي بعد البرنامج حيث كان قبل البرنامج (م = 62.978) ، ليصل بعد تطبيق البرنامج الي (م = 72.914) ، واظهرت ايضا نتائج الدراسة انه لاتوجد فروق ذات دلالة احصائية في مستوي المعرفة والاتجاه نحو عملية التعافي فيما يتعلق بالمتغيرات الديموغرافية (العمر – الجنس – مكان السكن – والمستوي التعليمي).

بناء علي ماوضحته نتائج الدراسة نستطيع ان نقول انه بجهد بسيط وتكلفة قليلة يمكن ان نحسن مستوي المعرفة ونحدث تغييرا في التجاه بالتالي نحو عملية التعافي وبهذا نقدم مستوي راقي من الخدمات النفسية والتأهلية للمرضي النفسيين في قطاع غزة ممايسهم في تخفيف العبء والمعاناه عن كاهل هذه الفئة المهمشة.

Contents

List of Abbreviations

GDP	Gross Domestic Product
GNP	Gross National Product
GS	Gaza Strip
ICRC	International Committee of Red Cross
JD	Jordanian Dinnar
MOF	Ministry Of Finance
MOH	Ministry Of Health
WHO	World Health Organization
CMHD	Community Mental Health Directorate
PSW	Psychosocial Worker
WRAP	Wellness Recovery Action Plan
RAQ	Recovery attitude Question
RKQ	Recovery Knowledge Question
NGO's	Non Governmental Organizations
NIS	New Israeli Shekel
PCBS	Palestinian Central Bureau of Statistics
PNA	Palestinian National Authority
OPT	Occupied Palestinian Territory
PHC	Primary Health Care
SPSS	Statistical Package for Social Sciences
UN	United Nations
UNRWA	United Nations Relief and Working Agency
USD	United States Dollar
WB	West Bank

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CHAPTER ONE

Chapter1

1.1 Background of the study

Recovery is perhaps the most recent and talked about paradigm in the mental health field. The early 1970s was the time of the community mental health movement and with this emerged the mental health recovery concept; The Recovery approach represents a paradigm shift in the relationship between the individual and mental health professionals. Current practice focuses on evidence based medicine, encouraged by professional groups and health provider organizations. However, although this is vital to providing high quality patient care, it is led by professionals. A Recovery approach will allow a more equal dialogue between professionals and service users and perhaps offer more innovative care. The shift that is required is one from professionals doing things 'to' people to supporting them to 'do' things for themselves, how they like and in their own way. Thus, rather than being the subject of treatment, the person would become the object in directing their own life, albeit with treatment and support. This represents a shift from being 'patient' to being active, and from being seen as the source of problems to becoming the source for solutions. This shift places a central emphasis on education (NSH foundation trust 2010)

Anthony defined recovery as "a deeply personal, unique process of changing ones attitudes values feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness" (Anthony, 2003). Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." Allott and colleagues suggested that individuals should be supported in their own personal development by placing the "emphasis on building self-esteem, discerning identity, and finding a meaningful role in society (Allott et al., 2002). In this view, recovery does not necessarily mean restoration of full functioning without supports (including medication); it does mean building on personal strengths and resources to develop supports and coping mechanisms which enable individuals to be active participants in—as opposed to passive recipients of—their mental health care." These perspectives imply that the concept of recovery should no longer be restricted to medical model definitions (symptom management or amelioration) or rehabilitation model definitions (improved

functioning) but should expand to emphasize psychological recovery processes (Andresen R, 2003). Providers of mental health services represent a very important environmental factor that can either help or hinder recovery (Antonak RF et al., 1988). Terrier and Barrowclough (Tarrier N et al, 2003) demonstrated that people with psychiatric and psychological disorders are significantly affected by interpersonal interactions, including those with mental health professionals. The degree of adoption of recovery-oriented principles and practices by mental health professionals may be influenced by their attitudes and hopefulness regarding the possibility of recovery. Hugo (Hugo M, 2001) found that mental health professionals were less optimistic than the general public about prognosis and longer-term outcomes for people with schizophrenia or depression. Others have suggested that the more negative attitudes of professionals may be more realistic and in line with greater knowledge of mental disorders, but they could also be biased as a result of the proportion of contacts they have with people with chronic and recurring disorders at times when significant interventions are required (Jorm AF et al, 1999). Rickwood stated, "Implementing a recovery orientation requires an attitude shift for many service providers in order to support consumer rights and provide the types of services that maximize well-being for people with mental illness." She also suggested that an understanding of the factors that affect recovery, rehabilitation, and relapse is essential (Rickwood D, 2004). Attitudes are thought to reflect the "mental readiness" or learned "disposition" that influence actions and reactions (Haddow M et al, 1995).

1.2 Research problem.

Mental health problem affect entire population of Palestinian people. This problem affect the total society and interfere with the developmental process, the way which followed to treat such problem is biologically based which focus on disability rather than strength and empowerment,so there is a need to a new trends to address such issue.

Recovery is perhaps the most recent and talked about paradigm in the mental health field. Which emphasis on hope, self-determination, quality of life and empowerment (Ochocka et al., 2005; Onken et al., 2002; Anthony, 2000). People with psychiatric and psychological disorders are significantly affected by interpersonal interactions,

including those with mental health professionals. The degree of adoption of recovery-oriented principles and practices by mental health professionals may be influenced by their knowledge and attitudes regarding the possibility of recovery. This study well examined the impact of training program based on Wellness Recovery Action Plan on psychosocial workers knowledge and attitudes related to the recovery process in Gaza strip.

1.3 Justification of the study

Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year. When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people, The National Survey of Mental Health and Wellbeing 2007 found that one in five (20%) Australian adult's experience mental illness in any year. One in four of these people experience more than one mental disorder. Based on these prevalence rates, over 3.2 million Australians had a mental disorder in the previous 12 months. In addition, mental disorders are the leading cause of disability in the U.S. and Canada for ages 15-44. Many people suffer from more than one mental disorder at a given time. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity, The burden of mental illness on health and productivity in the United States and throughout the world has long been underestimated. Data developed by the massive Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide, accounts for over 15 percent of the burden of disease in established market economies, such as the United States. This is more than the disease burden caused by all cancers; the mental health reports published by the Palestinian Authority (PA) from 2010 indicate increases in most mental disorder categories (see Table 1).For instance, it is known that the prevalence of affective disorders such as depression is dependent on social, economic and political conditions (Zimmerman and Katon 2005). Thus the increase in affective disorders and neurosis may reflect the deterioration of Palestinian life due to increased Israeli sieges, shelling, targeted killing and restrictions of movement. Increase in the prevalence of

epilepsy, a neurological disorder, may be attributed to obstacles in early detection and optimal treatment due to military sieges and other collective punishment measures. However, it is also possible that incidence figures vary because of a gradually improving reporting system. Epidemiological studies in the Gaza Strip found women and families lacking support from relatives and community to be more vulnerable to anxiety when exposed to military violence (Punama¨ki et al. 2005a, 2005). Some studies indicate poorer mental health outcomes in populations exposed to war and disasters, and a strong relationship between losses of family members and distress (Mollica et al. 2001, Cardozo et al. 2004). A study comparing mental health status in four war-affected societies, including the occupied Palestinians territory (OPt), Algeria, Burma and Ethiopia, found strong associations between military atrocities and losses and psychiatric distress (de Jong et al. 2001). Increased risk of mental health problems was also found among injured young Palestinians (Khamis 2008) and children experiencing family loss and home demolition (Khamis 2005) during the second intifada, All of this facts reflect the importance to search for new way to address this burden, Recovery model is one of this options which have good impact as research evade in mental health filed, there is no study was conducted from the researchers on Gaza strip on area of recovery and the role which may be played via community mental health workers if they have enough knowledge and positive attitude toward recovery. This study aimed to examine the impact of training program based on Wellness Recovery Action Plan on psychosocial workers knowledge and attitudes related to the recovery process in Gaza strip.

Table 1. Incidence rate of reported new cases of mental disorders in 2010 in the occupied Palestinianterritory (oPt).

Diagnosis	Rafahclinic		Abusheback clinic		Khanyouns Clinic		Alnusirate Clinic		West Gaza clinic		Alsuraney Clinic		Total
SEX	M	F	M	F	M	F	M	F	M	F	M	F	
ORGANIC	5	4	1	2	3	3	1	6	3	1	1	13	43
SCHIZOPHRENIA	7	6	4	4	2	5	16	3	6	2	17	12	84
NEUROSIS	27	17	7	2	16	3	6	3	8	5	10	3	107
PERSONALITY DISORDER	5	3	0	0	2	0	4	1	0	0	3	1	19
ADDICTION	2	1	4	0	3	0	2	0	2	0	6	2	22
EPILERSY	20	21	9	4	2	0	12	3	3	3	5	1	83
AFFECTIVE	15	8	4	3	0	1	12	7	7	2	11	6	76
MENTAL RETARDATION	12	8	8	2	7	6	14	7	8	6	27	23	128
OTHERS	3	1	3	0	5	0	4	0	4	5	4	2	31
Total	96	69	40	17	40	18	71	30	41	24	84	63	593

1.4 General objective:

This study aimed to understand the impact of training program based on Wellness Recovery Action Plan on psychosocial workers knowledge and attitude towards recovery approach.

1.4.1 Specific objectives:

- To identify the knowledge of recovery among psychosocial workers at community mental health directoratein Gaza strip.
- To identify the attitude of psychosocial workers at community mental health directorate in Gaza strip.
- To assess differences in knowledge among psychosocial workers about recovery process before and after the training program.
- To assess differences in attitude among psychosocial workers toward recovery process before and after the training program.
- To ascertain whether an association exist between knowledge and attitude in relation to socio-demographic characteristics (age, gender, level of educations).
- To suggest recommendation to policy and decision makers regarding the opportunity to improve mental health condition in Gaza strip by applying recovery principle.

1.4.2 Research questions:

1. Dose the psychosocial workers knowledgeable about recovery process?
2. Dose the psychosocial workers have positive attitude toward recovery process?
3. Are there statistical differences in knowledge about recovery before and after training program?
4. Are there statistical differences in attitude toward recovery before and after training program?
5. Is there an association exists between knowledge, attitude and socio-demographic characteristics (age, gender, level of education)?

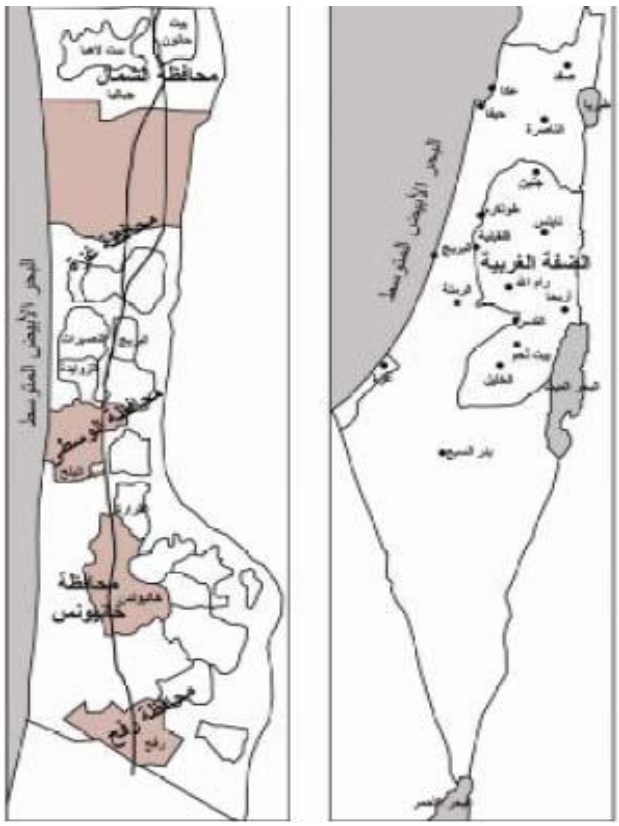
6. What are the recommendations that can be offered to policy and decision makers regarding the opportunity to improve mental health condition of mentally ill client?

1.5 Context of the study

The demographic, socioeconomic, and political situations greatly impact health in general and mental health in specific and health care services in Gaza strip and west bank, this context influence the services by specific way to suit these situations and to overcome our permanents emergency situation.

1.5.1 Demographic context

The entire area of historical Palestine is about 27,000 Km2, Palatine stretches from Ras Al- Nakoura in the north to Rafah in the south. Palestine is boarded by Lebanon in the north, the Gulf of Aqaba in the south, Syria and Jordan in the east and by Egypt and Mediterranean Sea in the west. Palestine was places under British mandate, finished by Israel establishment in 1948 in implementing The Balfour Declaration in 1917 to providing a homeland for Jews, the result was uprooted most of Palestinian from their cities, towns, and Villages and migrate to West bank, Gaza strip, Jordan, Lebanon, Syria, and others countries (Abu-Lughod, 1971).



Annex 1 Palestine map (Gaza Strip-left)

Gaza Strip is a narrow land, located on the south of Palestine on the coast of Mediterranean sea. Gaza Strip is high crowded area, where approximately 1.5 million live in 365 km2, estimated density is 4,000 people per square kilometer, the

Population is concentrated in 7 town, 10 villages, and 8camps (PCBS, 2008). And establishment census 2007 which indicates that the number of population in the Palestinian Territory during the fourth quarter 2009 was 3,743,050 (PCBS, 2010). The density is increase refugee camps (UNRWA, 2005). GS is classified into five governorates, North of Gaza, Gaza city, Mid-Zone, Khan-younis and Rafah. The population under 15 year old percentage in Gaza Strip is 49% and 2.5%of age 65 years and more(MOH, 2006).

1.5.2 Socio-economic and political situation:

The past years witnessed one of the most violent periods experienced by Palestinian civilians since the beginning of Israel's occupation in 1967. Between 27 December 2008 and 18 January 2009, 1.4 million Palestinian residents of the Gaza Strip endured intensive and continuous bombardment from land, sea and air in the course of Israel's "Cast Lead" military offensive, launched with the stated purpose of preventing indiscriminate rocket fire from Gaza (OCHA, 2009).

As a result of the last ware against Gaza, at 31 January the MOH and Palestinian health information center reported that 1380 Palestinian people had been killed since 27 December 2008, of whom 431 were children and 112 women. Approximately 5380 people were reported injured, including 1872 children and 800 women. Injuries were often multiple traumas with head injuries, thorax and abdominal wounds. Among the casualties, 16 health staffs were killed and 22 injured while on duty (MOH& PHIC, 2009).

Israel, the United States, Canada, and the European Union have frozen all funds to the Palestinian government, the severity of closure increased after political unrest in June, 2007, causing the closure of most factories to the lack of raw materials, loss of farmers by preventing the export of their crops. Prosecute deteriorating economic situation on the Gaza Strip led to the rise in unemployment rate to 65%, and 85% of households are living under the poverty line After Palestinian legislative election in 2006, (UNCTAD, 2007). According to Palestinian Ministry of Finance (MOF), the gross national product (GNP) in Palestine was 5.454 million US$ in 1999 and decreased to 3.720 million US$ in 2004. However, the gross domestic product (GDP) was 4.517

million US$ in 1999 and decreased to 3.286 million US$ in 2004 (World Bank, 2003).

The gross national product per capita (GNP / capita) was 1.806 US$ in 1999 and decreased to 979 US$ in 2004. While, the gross domestic production per capita (GDP /Capita) was 1.496 US$ in 1999 and decreased to 865 US$ in 2004.

1.6 Palestinian Health Care System

The Palestinian health care system is a combination of four major actors providing health care services to the Palestinian people inside the occupied Palestinian territory and to refugees from Palestine in the surrounding Arabs countries, Syria, Lebanon, Egypt, and Iraq. The four major subsystems are the MOH, Non Governmental Organization (NGOs), United Nations Relief and Working Agency (UNRWA), and private sector (MOH, 2006).

The MOH is still responsible for the largest portion of primary, secondary, and tertiary health care services for the Palestinian people resident in GS and WB, but no health services provided for the Palestinian people outside the occupied Palestinian territory by the MOH. The UNRWA is the largest humanitarian organization in the Near East; it has been the main primary health care provider for the refugees from Palestine not only in the occupied Palestinian territory but also in the surrounding Arabs countries.

1.7. Mental Health Service

The PA's Ministry of Health inherited from the Israeli military administration health services that had been neglected and starved for funds during the years of Israeli occupation (Giacaman et al. 2009). Mental health was particularly neglected. While the Palestinian Ministry of Health, with support from the World Health Organization (WHO), is continuing to make attempts to expand services beyond the hospital, most services continue to be hospital-based, fragmented and rooted in a biomedical oriented approach (WHO, West Bank and Gaza Office 2006). Currently, the Palestinian Ministry of Health (Report 2006, p. 35) operates two psychiatric hospitals, one in Bethlehem with 280 beds serving the West Bank, and another in Gaza City with 39 beds serving the Gaza Strip. These hospitals have dominated in formally providing for the mentally ill, with community services remaining patchy. In 2004 the Ministry was operating 13

mental health outpatient clinics, nine on the West Bank and four in the Gaza Strip. The mental health department of the Ministry of Education and Higher Education assures the presence of school counselors on a full-time or half-time basis to all public schools. In addition, the United Nations Relief and Works Agency (UNRWA) has been running a mixture of mental health and counseling services within the health and school system in the West Bank and Gaza Strip with programs fluctuating in response to the vagaries of funding (Steering Committee on Mental Health 2004). By 1995 ministry of health run 6 community mental health center distributed through Gaza governorates, one of them based in Rafah governorate, one in Khan-Younis governorate, one in Mid-Zone, two in Gaza city and one in north Gaza, according MOH planning to cover mental health services in community based, these mental health center provide counseling for mentally ill client and psychopharmacology treatments.

CHAPTER TWO

Conceptual framework and Literature review

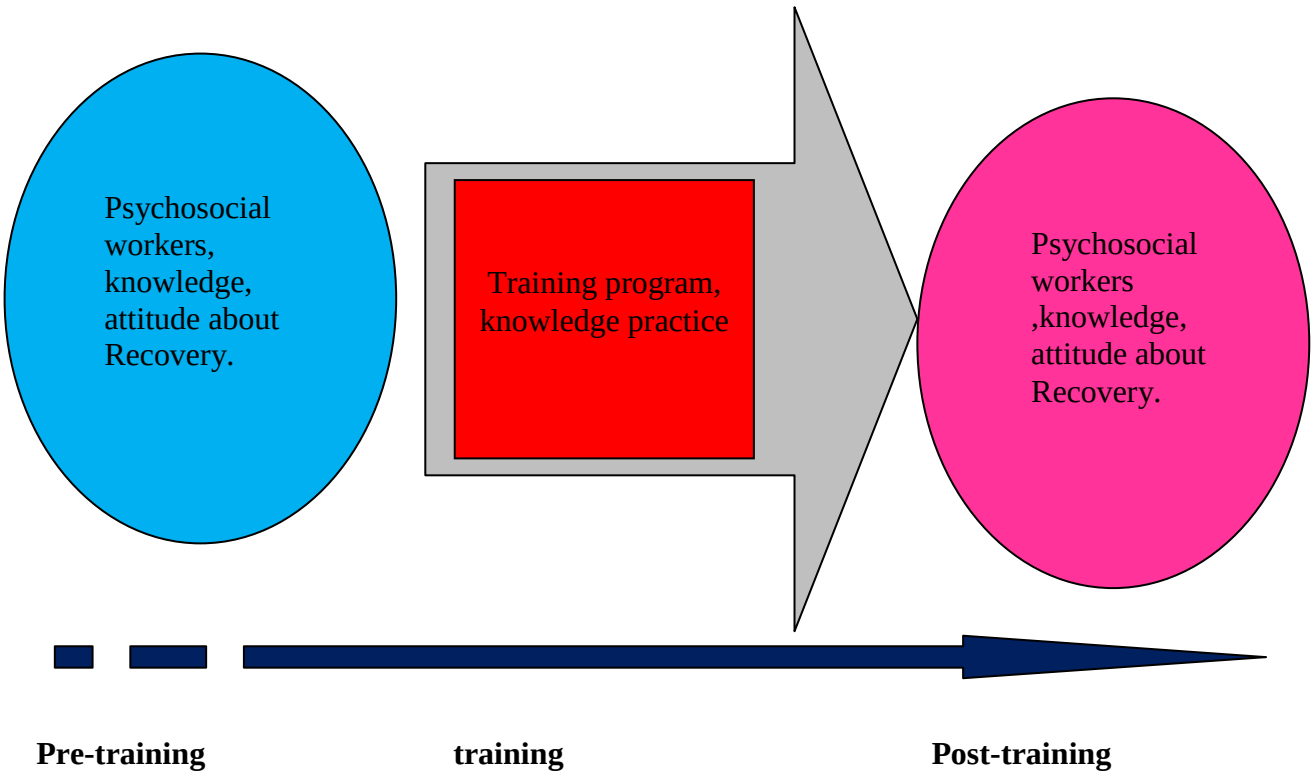
Chapter2:

Conceptual framework and Literature review

This chapter reviews the literature about recovery from mental health, historical development of recovery, process and components of recovery, key principles in recovery approach, Views of Recovery, The Role of Providers in Recovery, Recovery Guidelines, and other thing related to the topic.

2.1 Conceptual framework

Conceptual frame work of the research study is self developed**.** This frame work shows the domains in this study including knowledge, attitude, and psychosocial workers before and after training program, this simple framework use by the researcher as a guide for the research process. The framework shows attitude, knowledge and psychosocial workers, where all of these domains may affect by training program.



2.2 Definitions:

2.2.1. Operational definitions of psychosocial worker:

It includes of psychologist and social worker whom work in community mental health directorate as fixed term employers.

2.2.2. Knowledge:

Knowledge is defined by the Oxford English Dictionary as expertise, and skills acquired by a person through experience or education; the theoretical or practical understanding of a subject; what is known in a particular field or in total; facts and information; or be absolutely certain or sure about something in this study the subject is the recovery concept. (Webster's dictionary 1984)

2.2.3. Attitude:

An attitude is an opinion that one has about someone or something. It can reflect a favorable, unfavorable, or neutral judgment. Attitudes are thought to reflect the "mental readiness" or learned "disposition" that influence actions and reactions (Haddow M et al, 1995).

We may have attitudes about many things. For example, we have attitudes about people, political issues, pets, music, art, movies, books, and education.

Attitudes may reflect both beliefs and feelings. For example, a positive attitude concerning a psychology course may include the belief that the course involves learning about something that is important to your life and the feeling that you like the course.

2.2.4. Recovery:

2.2.4.1. Theoretical definitions

While there are many definitions of recovery, ultimately recovery is defined by the individual consumer and consists of basic principles such as having hope, choice, self-determination, and personal responsibility. Recovery also involves finding one's niche or gift in life.

According to Webster's Dictionary (1984): The formal definition of the word recovery means "to get back: regain" or "to restore (oneself) to a normalstate (Onkenand others, 2002:7).

Recovery is defined in the report of the NFCM at 2003 as the processes, in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

Chamberlin (1997): said "One of the elements that makes recovery possible is the regaining of one's belief in oneself (Ralph, 2000:7).

Beale & Lambric(1995): indicates Recovery includes personal empowerment and a spirituality/philosophy, which gives meaning to life. It is accomplished one step at a time. It is deeply personal, and can be done only by the individual who is recovering.

DeMasi (1996): recovery It includes physical and mental health, and economic and interpersonal well-being (Ralph, 2000:8).

Long (1994): a recovery paradigm is each person's unique experience of their road to recovery.recovery paradigm included reconnection which included the following four key ingredients: connection, safety, hope, and acknowledgment of my spiritual self (Ralph, 2000:8).

Blanch (1993): recovery It involves hope, courage, adaptation, coping, self esteem, confidence, a sense of control or free will (Ralph, 2000:8).

Mental health recovery is a journey of healing and transformation enabling a person with mental health problem to live a meaningful life in the community of his or her choice while striving to achieve his or her potential (US department of health and human services, 2004:1),.

Spaniol and others (1994): Recovery is the process by which people with psychiatric disability rebuild and further develop these important personal, social, environmental, and spiritual connections, and confront the devastating effects of stigma through personal empowerment. Recovery is the process of adjusting one's attitudes, feelings, perceptions, beliefs, roles, and goals in life. It is a process of self-discovery, self-renewal, and transformation.

Andresen et al (2003): there are several meanings of the recovery concept which developed from the consumer movement These definitions presumably fall along a continuum: the medical model definition, the rehabilitative model definition, and the empowerment model definition According to the medical model, mental illness is viewed as a disease and recovery occurs when an individual is "cured"—when he or she returns to their former health state prior to the onset of their mental illness.

According to Andresen et al (2003): The second definition along this recovery continuum is the rehabilitative model, which states that mental illness is incurable, but the individual is often able to return to some resemblance of their former mental health state.

Andresen et al (2003): define Psychological recovery as the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination" Psychological recovery differs from the aforementioned, and has been found to be most compatible with consumer beliefs, because it makes no statement about the cause of mental illness, the necessity of medication, does not define recovery by roles valued by society, or define whether the illness is still present during recovery—it actually allows for the presence of symptoms and ongoing management of the illness in the midst of recovery.

Markowitz (1996): said The recovery process is involve symptom control, dealing with discrimination and stigma by society, regaining a positive sense of self, and attempting to lead a satisfying and productive life.

Pat Deegan (1995): The concept of recovery is rooted in the simple yet profound realization that people who have been diagnosed with mental illness are human beings. Like a pebble tossed into the center of a still pool, this simple fact radiates in ever-larger ripples until every corner of academic and applied mental health science and clinical practice are affected. Those of us who have been diagnosed are not objects to be acted upon, we are fully human subjects who can act and in acting, change our situation. We are human beings and we can speak for ourselves. We have a voice and we can learn to use it. We have a right to be heard and listened to. We can become self-determining. We can take a stand toward what is distressing us and need not be passive victims of an illness. We can become experts in our own journey of recovery. The goal of recovery is not to get mainstreamed. We don't want to be mainstreamed. We say let the mainstream become a wide stream that has room for all of us and leaves no one stranded on the fringes." (Deegan: 1996).

Bill Anthony (1993): Recovery is a process and experience that we all share. People face the challenge of recovery when they experience the crises of life, such as the death of a loved one, divorce, physical disabilities, and serious mental illness
It's the way of living satisfying and contributing life even with the limitations caused by illness
(Anthony 1993).

2.2.4.2. Operational definitions of recovery:

The researcher adopted the NFCM definition at 2003 as the processes, in which people are able to live, work, learn and participate fully in their communities., and ability to live a fulfilling and productive life despite a disability (NFCM: 2003).

2.2 Literatures reviews

After reviewing the literature regarding recovery , the researcher find that the efforts in this area of mental health concerned were became the focused of researchers in the last years, aiming to explore this option of dealing with mentally ill, that promote strengths and empowerment of people with mental disorders, and shifting them from being dependent to be more independent.

2.2.1. Recovery terminology and associated concepts

Some people use terminology with similar or slightly different meanings from recovery. It is unhelpful to see these associated concepts as in competition with one another as the recovery concept can encompass all of these meanings, but is not restricted to any one of them:

• ***Rehabilitation:*** an organized statutory or voluntary sector program designed to improve physical, mental, emotional and social skills to enable a transition back into society and the workplace.

• ***Discovery:*** taking a personal journey to new understandings of oneself and the world, rather than simply returning to the old self.

• ***Restitution:*** regaining some of what has been lost or taken away due to ill-health, for example, social status, contacts, self-esteem.

• ***Self-care***: looking after oneself well.

• ***Self-management***: making one's own health decisions and learning to manage long-term health problems, so as to live well with the minimum reliance on services.

• ***Self-directed care***: being informed and having the ability to exercise choice and responsibility for care provided to you by others.

• ***Coping strategies and strategies for living***: finding what helps one cope with problems and building one's own set of tools for dealing with mental or physical health problems.

• ***Healing and wellness***: rediscovering one's inner capacity for self-healing, with or without help from a practitioner and achieving a state of well-being, even if some of the symptoms remain.

• ***Resilience***: having the ability to survive and to learn from life's challenges. A common purpose

• ***Transformation***: a term used with respect to a process, outcome and vision for individuals and services that is not an end in itself but rather an intermediate state through which the goal of facilitating recovery in people's lives is realized. (Ralph: 2000).

2.2.2 Historical development of recovery:

Prior to the mid 1980's, and before the deinstitutionalization movement, common parlance suggested that the future of a person with a serious mental illness was

bleak and fraught with continued deterioration (Surgeon General, 1999). The possibility of rehabilitation or recovery from life-long mental illness was not even considered; traditionally, the goal of treatment was to prevent decompensation, treat symptoms, maintain stability, and handle crises (Anthony, 2000; Ralph & Muskie, n.d.; Turner-Crowson & Wallcraft, 2002). Attitudes toward individuals with mental illnesses have become more favorable during the past twenty-five years. Due to the writings of consumers of mental health services about their experiences in the mental health system and the resulting "consumer movement," the 1980's and 1990's were marked by a shift in focus that occurred within the mental health professions. A new vision of mental health treatment emerged and it became known as the "recovery model" (Anthony, 1993; Surgeon General, 1999). Anthony (1993) defines recovery as, a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning in one's life as one grows beyond the catastrophic effects of mental illness.

2.2.3. The Consumer-Survivor Movement:

Gonzalez (1976) said health care and mental health care have followed a prescriptive model in which the client presents with a problem and the health care provider decides what route is best to take to help reduce or eliminate the symptoms, as consumers gained knowledge about the mental health system, along with societal advances and increased expectations, these individuals became more vocal about their needs.

Beginning in the 1950s, escalating in the 1960s, and becoming solidified in the 1970s, these consumers (who were originally groups organized of lay persons) have organized into consumer-oriented organizations that exist on all governmental and societal levels**.** These organizations insist that each consumer has a voice in the delivery and decision-making processes of their mental health services.

Wilson et al (1999) said consumer-oriented organizations pursue a model of care in which the client is an active and informed participant in their treatment and recovery (Hugo, 2001**).**

Frese & Davis (1997) noticed the pioneers and followers of this movement support the principle that no person shall be hospitalized involuntarily, as well as agreeing upon the government's right to subject dangerous (even though mentally unstable) individuals to the criminal justice system, The consumer-survivor movement began in the United States immediately following the Civil War.

McLean (1995) describes Empowerment is an important concept in the consumer-survivor movement, as well as in recovery research. To the mental health consumer, empowerment embodies self-determination and control over their lives, in addition to their treatment, and has become the fundamental goal of many consumers (Ralph, 2002).

Anthony (1993) said after the period of psychiatric deinstitutionalization, the ideas of recovery began to grow.

Corrigan & Phelan (2004) said the consumer-survivor movement served to give hope to those diagnosed with severe mental illness (SMI), and as a result the recovery vision from the consumer-survivor perspective is most concerned with the process of recovery.

According to Ellis & King (2003) The idea of a recovery vision for mental health consumers has resulted from both the consumer-survivor movement's gains in patient rights, as well as the mental health profession's gains in knowledge about the prognosis of SMI.

2.2.4 Fundamental Components of Recovery.

- **Self-Direction**: Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered**: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her

needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities.
- **Non-Linear**: Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
- **Strengths**-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles.
- **Peer Support**: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

- **Respec**t: Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. (US department of health and human services, 2004:1).

2.2.5 Key themes in recovery include the following:

Deegan, (1988), Leete, (1989); Unzicker, (1989) determine common themes of recovery as the following.

1. Recovery is the reawakening of hope after despair.
2. Recovery is breaking through denial and achieving understanding and acceptance.
3. Recovery is moving from withdrawal to engagement and active participation in life.
4. Recovery is active coping rather than passive adjustment.
5. Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self.
6. Recovery is a journey from alienation to purpose.
7. Recovery is a complex journey.
8. Recovery is not accomplished alone–it involves support and partnership.
9. Recovery is fundamentally about a set of values related to human living applied to the pursuit of health and wellness.

10. Recovery involves a shift of emphasis from pathology, illness and symptoms to health, strengths and wellness
11. Hope is of central significance. If recovery is about one thing it is about the recovery of hope, without which it may not be possible to recover and that hope can arise from many sources, including being believed and believed in, and the example of peers.
12. Recovery involves a process of empowerment to regaining active control over one's life. This includes accessing useful information, developing confidence in negotiating choices and taking increasing personal responsibility through effective self-care, self-management and self-directed care.
13. Finding meaning in and valuing personal experience can be important, as ispersonal faith for which some will draw on religious or secular spirituality.
14. Recognizing and respecting expertise in both parties of a helping relationship which re- contextualizes professional helpers as mentors, coaches, supporters, advocates and ambassadors.
15. Recovery approaches give positive value to cultural, religious, sexual and other forms of diversity as sources of identity and belonging.
16. Recovery is supported by resolving personal, social or relationship problems and both understanding and realistically coming to terms with ongoing illness or disability.
17. People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles in society and gaining access to mainstream services that support ordinary living such as housing, adequate personal finances, education and leisure facilities.
18. There is a pivotal need to discover (or rediscover) a positive sense of personal identity, separate from illness and disability.
19. The language used and the stories and meanings that are constructed around personal experience, conveyed in letters, reports and conversations, have great significance as mediators of recovery processes. These shared meanings either support a sense of hope and possibility or carry an additional weight of morbidity, inviting pessimism and chronicity.
20. Services are an important aspect of recovery but the value and need for services will vary from one person to another. For some people, recovery is equated with detaching from mental health services either permanently or for much of the time.

For others, recovery may be associated with continuing to receive ongoing forms of medical, personal or social support that enable them to get on with their lives.

21. Treatment is important but its capacity to support recovery lies in theopportunity to arrive at treatment decisions through negotiation andcollaboration and it being valued by the individual as one of many tools theychoose to use.
22. The development of recovery-based services emphasizes the personal qualities of staff as much as their formal qualifications, and seeks to cultivate their capacity for hope, creativity, care and compassion, imagination, acceptance, realism and resilience.
23. In order to support personal recovery, services need to move beyond the current preoccupations with risk avoidance and a narrow interpretation of evidence based approaches towards working with constructive and creative risk-taking and what is personally meaningful to the individual and their family. (Unzicker:1989)

2.2.6 Recovery Guidelines

Researchers have developed numerous guidelines designed to increase recovery-oriented services and promote positive consumer-provider relationships (Anthony, 1993; Bishop, 2001; Chamberlin, Rogers, & Sneed, 1989; Deegan, 1988; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Smith, 2000). Some of the guidelines set forth for providers include:

(1) treating the person as an equal; (2) focusing on the person and his/her needs; (3) recognizing the individual nature of recovery; (4) focusing on the individual's goals and decisions; (5) encouraging hope and accountability; (6) providing self-help skills; (7) ensuring collaborative treatment; (8) encouraging connection with others who experience mental illness; (9) encouraging peer support; and (10) making referrals to consumer-run groups (Anthony, 1993; Bishop, 2001; Chamberlin et al., 1989; Deegan, 1988; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Smith, 2000).

A provider's effectiveness is enhanced by having a positive attitude about the difference he/she can make in a consumer's life, and believing in the possibility that each consumer can be empowered and can recover (Anthony, 1993; Bishop, 2001; Chamberlin et al., 1989; Deegan, 1988; Jacobson & Greenley, 2001; Mead & Copeland, 2000; Smith, 2000). The importance of provider attitude is emphasized in the

following: “it is important to recognize that no service is recovery oriented unless it incorporates the attitude that recovery is possible and has the goal of promoting hope, healing, empowerment, and connection” (Jacobson & Greenley, 2001, p. 483).

Guiding principles have also been developed for integrating the recovery model into mental health services for the people who develop or manage mental health systems. Some of these guidelines overlap with the previously-listed guidelines for "front-line" providers (e.g., incorporation of peer support; recognizing the individual nature of recovery). To be consistent with the recovery model, people who develop or manage mental health systems are advised to: (1) expect a dynamic process; (2) provide participants with multiple services from which they can choose; (3) hire recovering consumers; (4) support consumer-operated services; (5) incorporate consumers and their rights in the planning, development, and implementation of services; and (6) ensure equal access to care for all consumers. Those who develop or manage mental health systems are also encouraged to: (7) incorporate recovery in all aspects of the system including the leadership and management within the system; (8) be culturally relevant and competent; (9) implement stigma reduction policies; (10) emphasize relapse prevention and management; (11) advocate for recovery and for consumers in the community as well as the mental health system; and (12) educate providers about the recovery concept (Anthony, 2000; Jacobson & Curtis, 2000; Jacobson & Greenley, 2001). As evidenced above, many guidelines for recovery-oriented services exist for providers and the mental health system. Additionally, during the 1990’s, many states and counties adopted the recovery concept to guide their service delivery (Anthony, 2000). Some researchers suggest that the recovery concept coincides with the shift toward a managed approach to mental health care; recovery principles are viewed as providing cost-effective, measurable outcomes (Jacobson & Curtis, 2000).

2.2.7 Assumptions about recovery Anthony (1993):

- Recovery can occur without professional intervention. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumers’ natural support system. … Self help groups, families and friends are the best examples. … Also essential to recovery are

non-mental health activities and organizations, e.g., sports, clubs, adult education and churches…

- A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery, a person or persons in whom one can trust to "be there" in times of need.
- A recovery vision is not a function of one's theory about the causes of mental illness.
- Recovery may occur whether one views the illness as biological or not.
- Recovery can occur even though symptoms reoccur. The episodic nature of severe mental illness does not prevent recovery.
- Recovery changes the frequency and duration of symptoms. As one recovers, the symptom frequency and duration appear to have been changed for the better. That is, symptoms interfere with functioning less often, and for briefer periods of time … and return to previous function occur more quickly after exacerbation.
- Recovery does not feel like a linear process. Recovery involves growth and setbacks, periods of rapid change and little change … The recovery process feels anything but systematic and planned.
- Recovery from the consequences of the illness is sometimes more difficult thanrecovering from the illness itself. Issues of dysfunction, disability, and disadvantage are often more difficult that impairment issues. An inability to perform valued tasks and roles, and the resultant loss of self esteem, are significant barriers to recovery.
- Recovery from mental illness does not mean that one was not really mentally ill. People who have recovered or are recovering from mental illness are sources of knowledge about the recovery process and how people can be helpful to those who are recovering (Anthony: 1993).

2.2.8 Dimensions of recovery found in personal accounts Ralph (2000):

internal factors: factors that are within the consumer, such as awareness of the toll the illness has taken, recognition of the need to change, insight as to how this change can begin, and the determination it takes to recover.

Self-managed care: an extension of the internal factors in which consumers describe how they manage their own mental health and how they cope with the difficulties and barriers they face.

Externalfactors: include interconnectedness with others, the supports provided by family, friends, and professionals, and having people who believe that they can cope with, and recover from, their mental illness.

empowerment: a combination of internal and external factors—where internal strengths are combined with interconnectedness to provide self-help, advocacy, and caring about what happens to ourselves and to others (Onken et al, 2002:8)

2.2.9 The difference between rehabilitation and recovery:

Psychiatric and psychosocial rehabilitation involve targeted interventions which aid individuals to acquire and apply the skills, supports, and resources required to live a fulfilled life in their chosen community with minimal ongoing professional intervention. The aim of rehabilitation is the restoration of function and minimization of psychiatric disability through the development of strengths, restoration of hope, environmental modifications, and enhancement of vocational potential and maximization of social and recreational networks.

Deegan (1988) said Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn to adapt to theirworld. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability'

Recovery then forms the basis upon which rehabilitation services can be developed. It provides a framework that goes beyond offering people somewhere to go during the day. A framework of recovery ensures that hope, respect and pathways to community participation are incorporated into the day to day activities of rehabilitation programs, and rehabilitation services should not be considered the only vehicle for recovery. Instead rehabilitation services are one component of a comprehensive service system that collectively works towards the goal of recovery (Deegan: 1988).

2.2.10 Recovery and the medical model:

Allott (2003) said there are differences between the recovery and medical model.

The recovery model focuses on the following:

- Distressing experience
- Interest centered on the person
- Pro-health.
- Strengths based.
- Experts by experience.
- Personal meaning.
- Understanding
- Humanistic.
- Growth and discovery.
- Choice.
- Transformation.
- Self management.
- Self control
- Personal responsibility.

The medical model focuses on the following:

- Psychopathology
- Interest centered on the disorders.
- Anti-disease.
- Treatment based.
- Doctors and patients.
- Diagnosis.
- Recognition.
- Scientific
- Treatment
- Compliance
- Return to normal
- Experts care coordinators

- Bringing under control.
- Professional accountability (Allot ,2003).

2.2.11 Views of Recovery

2.2.11.1. Consumers' views of recovery

Many consumers have shared personal accounts of their experiences with mental illness and their recovery as well as their views on recovery as a concept. Consumers tend to focus on the process of reclaiming one's life while validating oneself as a competent, autonomous individual (Deegan, 1988; Jacobson & Curtis, 2000). For consumers, such as Patricia Deegan, the process of recovery has to do with empowerment and the "real life experience of persons as they accept and overcome the challenge of the disability" (Deegan, 1988, p. 11). For many consumers, recovery has little to do with rehabilitation outcomes or services made available to the person; it is not sudden, it does not imply the absence of symptoms, it does not refer to an end product, and it is not a linear process. Rather it is "a process, a way of life, an attitude, and a way of approaching the day's challenges" (Deegan, 1988, p. 15).

Some common themes about the recovery process have emerged from the first-hand accounts of consumers. These themes include: taking responsibility for one's own psychological and physical wellness; returning to basic functioning (Young & Ensing, 1999); accepting one's illness; having desire and motivation to change; and finding hope in oneself, other people, and/or in spirituality (Deegan, 1988). Consumers have also emphasized the importance to the recovery process of education about mental illness, advocacy, peer support, and gaining insight about the self and about mental illness (Mead & Copeland, 2000). The following themes have also emerged from the writings of consumers about recovery: improving quality of life and standard of living; increasing self-esteem; maintaining a positive focus; increasing independence; and striving to find new purpose in life (Young & Ensing, 1999). The experience of recovery is eloquently summarized in the following statement made by a consumer: those of us who have experienced psychiatric symptoms are…learning from each other that these symptoms do not have to mean that we must give up our dreams or our goals… We have learned that we are in charge of our own lives and can go forward and do whatever it is we want to do (Mead & Copeland, 2000, p. 316).

2.2.11.2. Providers' views of recovery.

Mental health researchers and providers often have a somewhat different view: they tend to approach mental illness from a psychiatric rehabilitation perspective. The goal of rehabilitation is to help consumers live well within the context of their illnesses (Andresen, Oades, & Caputi, 2003). There is increased attention to consumers' functioning, with a focus on improving consumers' status in various domains including employment, relationships, and housing. Providers tend to focus on providing services to consumers to improve functioning, to assist the rehabilitation process, and to promote recovery (Anthony, 1993; Jacobson & Curtis, 2000). The emphasis for many providers is on the services offered rather than on the process of empowerment that is so important to consumers. Although some differences exist in how providers versus consumers conceptualize the recovery process, (i.e., focusing on rehabilitation outcomes versus empowerment and autonomy), there are common themes in both conceptualizations. Both consumers and providers view recovery as a process that is unique to each individual, is active, and requires that individuals take personal responsibility for the process. Recovery emphasizes choice, hope, and purpose in one's life (Andresen et al., 2003; Anthony, 1993; Deegan, 1988; Jacobson, 2001; Jacobson & Curtis, 2000; Mead & Copeland, 2000; Young & Ensing, 1999). In addition, consumers and researchers agree that self-esteem, self-efficacy, and empowerment are better indicators of recovery than is a quantification of symptomatology, implying that recovery has more to do with sense of self than mental illness (Bullock, Ensing, Alloy, & Weddle, 2000; Deegan, 1996).

2.2.12 The Role of Providers in Recovery

Another essential component of the recovery process is support. In order to facilitate recovery for consumers, the mental health system and mental health providers must be recovery oriented. In his seminal work, Anthony (1993) described some basic assumptions of a recovery oriented mental health system. Two of these assumptions directly relate to the role of providers:

(1) Recovery can occur without providers, and (2) recovery includes the presence of people who support and believe in the recovery process for the person who is recovering (Anthony, 1993). These assumptions highlight the importance of a

provider's attitude (if a recovering consumer chooses to involve a provider in his/her recovery process). A consumer's decision to include a provider in his/her recovery process may depend upon whether past relationships with providers have been positive or negative. Interactions with mental health providers have been devastating for some consumers, especially when providers have informed them that the chance for their recovery is minimal (Coleman, 1999). Others have described experiences in which providers have made assumptions about the seriousness of the illness and about issues such as suicidality based solely upon diagnostic labels. Many consumers have terminated treatment as result of being treated as a "label".

(According to Jacobson (2001), in some cases, in order for recovery to be successful, it is essential for a person to disengage with people (mental health providers, family) who inhibit the recovery process. These examples highlight the problems inherent in a consumer-provider relationship when treatment is focused more upon diagnosis than upon an individual's unique needs.

Conversely, according to the recovery model, an effective provider can facilitate the recovery process when he/she adopts the basic assumptions of a recovery-oriented mental health system (Jacobson, 2001). Providers who hold positive attitudes toward recovery are thought to promote empowerment and encourage an optimistic approach to the treatment of mental illness (Corrigan, 2002). Research focusing on provider service characteristics and consumers' needs and outcomes, found that consumers who felt empowered within the consumer-provider relationship (including the notion that providers were responsive to consumers' requests), were more likely to perceive that their needs were met, which in turn predicted lower levels of symptomatology and higher quality of life (Roth, & Crane-Ross, 2002). This research demonstrates the positive impact of providers on the recovery process. Ralph (2000) describes the powerful effects that mental health providers, family members and friends can have on those suffering from mental illness, stating that, "as they listen to the disclosures and see the personal pain, they can believe, they can encourage, they can provide hope, and they can treat people who have mental illness with respect and dignity, and by so doing, they can help the healing/recovery processes begin a continue". Frese & Davis (1997), both of whom are providers as well as consumers of mental health services, lend support to the importance of provider involvement in the recovery process. They note

that, “a key element in recovery is the presence of people who offer hope, understanding, and support; who encourage self-determination; and who promote self-actualization”. The authors go on to describe how psychologists can support this process by helping consumers realize their goals and potentials rather than focusing on their mental illnesses (Frese & Davis, 1997).

Additionally, Ware et al., 2004 conducted study which include interviews with 51 consumers highlighted consumers’ views on what constituted quality consumer-provider relationships, Common themes emerged including the importance of consumer input in treatment planning and implementation, and having a sense of connectedness with providers. Both of these helped the consumers in the sample to feel cared for while they struggled with mental illness. Other researchers have focused on “hope”, which is a key component of the recovery construct. The findings of 15 staff interviews in inpatient and outpatient settings conducted by Bryne et al., 1994, suggest that the consumer-provider relationship can foster hope in the consumer and promote belief in the consumer’s abilities; this serves as a powerful motivator for change (Psychiatric Services 58:1434–1439, 2005).

2.2.13 Illustrate Providers’ Knowledge of and Attitudes toward Recovery

Despite the proliferation of guidelines for recovery-oriented systems and the number of systems claiming to embrace the concept, it would be erroneous to assume that all mental health systemsand the providers that work for these systems have knowledge of, are accepting of, and have implemented recovery principles in day-to-day work (Smith, 2000). Surely, in some mental health systems, little is known about the recovery concept; hence, other methods of treatment (e.g., the medical model) are preferred over the recovery model. Also, in some settings, the recovery concept may be invoked in name only, leading those who are committed to promoting the recovery concept to fear that the mental health system risks, “promulgating a cosmetic initiative that maintains the dependence of individuals on the system” (Jacobson & Curtis, 2000, p. 339). It is also possible that some providers may not accept the recovery concept because they have not been convinced of its effectiveness. Proponents of the recovery model have purported that providers’ rejection of this concept could be a reaction to the consumer movement and the principle of consumer empowerment, both of which are

integral to recovery principles but may threaten the traditional mental health power structure that typically imbues power to the providers (Smith, 2000).

Some providers may reject recovery principles in the belief that consumers are "incompetent with limited ability to become peer service providers and advocates" (Chamberlin et al., 1989, p. 98-99). These attitudes are incompatible with the successful implementation of recovery principles in the mental health system in the other countries (eg. Canada, England, USA). As is evidenced above, some providers seem to have rejected the recovery concept (Chamberlin et al., 1989; Smith, 2000). It is imperative to note that not all providers are anti-recovery. By other accounts, providers have had positive effects on the recovery process (Corrigan, 2002; Frese &Davis, 1997; Jacobson, 2001), and therefore, it can be assumed that some providers do subscribe to the recovery concept. It is also possible that providers may be partially invested in the theory. Research clarifying how providers view the recovery concept is necessary. It would be illuminating to investigate the degree to which providers are aware of recovery concepts, what attitudes they hold about these concepts, and if recovery concepts are being embraced in local mental health systems? These questions warrant further investigation and are the subject of this project.

2.2.14. The Wellness Recovery Action Plan (WRAP)

The Wellness Recovery Action Planning is a program for recovery, this program was developed by Mary Ellen Copeland and others following their own personal mental illness and recovery experience in United States of America, and other area around the world. WRAP consists of five key concepts of mental health recovery: hope, personal responsibility, education, self-advocacy and support, and a personal action plan involving a system for the self-monitoring of symptoms (Copeland, M. 2000). WRAP has been widely recognized as an effective personalized recovery method and evidenced by its use by many mental health sufferers internationally, WRAP designed to help individuals in managing his life issues, overcome serious mental illness, reduce their susceptibility to the illness, and cope effectively with their symptoms, through developing daily maintenanceplan, Identifying triggers and an action plan, Identifying early warning signs and an action plan, Identifying signs that things are breaking down and an action Plan, Crisis planning and post crisis planning.

2.3. Previous study

2.3.1. Study conducted by Trevor, P.et al., **Effectiveness of a Collaborative Recovery Training Program in Australia in Promoting Positive Views about Recovery,** this study aimed to examined the impact of a two-day, recovery-based training program for mental health workers on knowledge, attitudes, and hopefulness related to the recovery prospects of people with enduring mental illness, A self-report pre-post training repeated-measures design was used with 248 mental health workers from the community-based government health sector (N=147) and non-government organizations (N= 101) in eastern Australia, Staff attitudes and hopefulness improved after training. Trainees significantly increased their knowledge regarding principles of recovery and belief in the effectiveness of collaboration and consumer autonomy support, motivation enhancement, needs assessment, goal striving, and homework use. Conclusions: This preliminary evidence indicates that staff recovery orientation can improve with minimal training. (Psychiatric Services 57:1497–1500, 2006)

2.3.2. Study conducted by Wenli Z.et al**., (The effectiveness of the Mental Health Recovery (including Wellness Recovery Action Planning Program with Chinese consumers),**This study aimed to examined the effectiveness of the Western style of Mental Health Recovery including Wellness Recovery Action Planning (commonly referred to as WRAP) in improving the recovery of the members of a Chinese mental health consumer's self-help organization in New Zealand.

A qualitative research method was conducted in this study. The researchers developed semi-structure questionnaires for interviews in individuals and focus groups with the supports from mentors. A research focus group was arranged to discuss the purpose of the proposed research and the importance of ownership of this research by Bo Ai She members. The positive response from members of Bo Ai She was overwhelming. Voluntary participants from members received a written information sheet in Chinese and a consent form to sign. In order to collect information from various resources, individual consumers who had developed WRAP plans, mental health professionals and family members were interviewed in individual and group settings. Eight voluntary consumers and three mental health professionals were interviewed individually. Five family members and five consumers participated in two

focus groups prospectively. Participant's profiles are presented in Table One, Key findings from this research affirmed that the WRAP program has played a significant role in recovery for many Chinese consumers. The result also suggested areas which need to be modified in order to become a culturally appropriate approach, (Psychiatric Services 67:1397–1400, 2006).

2.3.3. Study conducted by Barbic, S.et al., (**A Randomized Controlled Trial of the Effectiveness of a Modified Recovery Workbook Program: Preliminary Findings).** The study examined the effectiveness of the Recovery Work-book as a group intervention for facilitating recovery of persons with serious mental illness, the multicenter, and prospective, single-blind, randomized controlled trial was used included 33 persons who were receiving assertive community treatment services. For 12 weeks, a control group (N=17) received treatment as usual and an intervention group (N=16) received Recovery Workbook training in addition to usual treatment. At study entry and within three days of completion of the intervention, participants' perceived level of hope, empowerment, recovery, and quality of life were measured with the Herth Hope Index, the Empowerment Scale, the Recovery Assessment Scale, and the Quality of Life Index, respectively. Repeated-measures analysis of variance was used to examine between-group differences, Participation in the intervention group was associated with positive change in perceived level of hope, empowerment, and recovery but not in quality of life. The associations remained after analyses controlled for demographic variables, (Psychiatric Services, VOL. 60, No. 4).

2.3.4. Study conducted by Judith A. Cook, PhD. **(Initial Outcomes of a Mental Illness Self-Management Program Based on Wellness Recovery Action Planning),** This study examined changes in psychosocial outcomes among participants in an eight-week, peer-led, mental illness self-management intervention called Wellness Recovery Action Planning (WRAP), Eighty individuals with serious mental illness at five Ohio sites completed telephone interviews at baseline and one month after the intervention, Paired t tests of pre- and post intervention scores revealed significant improvement in self-reported symptoms, recovery, hopefulness, self advocacy, and physical health; empowerment decreased significantly and no significant changes were observed in social support. Those attending six or more sessions showed greater improvement than those attending fewer sessions, (Psychiatric Service. 2009 Feb; 60(2):246-9)

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2.3.5. Study conducted by Connell M.et al.,**(Can Employment Positively Affect the Recovery of People with Psychiatric Disabilities?**, This study explored the relationship between employment and recovery in individuals with psychiatric disabilities and proposed that participants who were employed would have higher levels of recovery than participants who were not employed, Data were analyzed from a pre-existing data-set produced in a large scale NHMRC project conducted as part of the Australian Integrated Mental Health Initiative (AIMhi), High Support Stream. Participants were 344 people with a range of psychiatric illnesses who received support from 11 public sector and non-government mental health organizations in Queensland and New South Wales, Australia. Scores on the Recovery Assessment Scale (RAS) were compared between those participants who were engaged in paid employment and those who were not, the results revealed that there was no difference in total recovery scores between those who worked and those who did not work. This finding indicated that higher recovery scores were not associated with participants who were employed. Also contrary to expectations, the results showed that workers scored lower than non-workers on the RAS factor described as "reliance on others" and there was a trend towards significance in the same direction on the factor "willingness to ask for help." *Conclusions and Implications for Practice:* Further research needs to be conducted to determine if the differences between workers and non-workers on the above factors represent a personal variable such as independence or self-determination that is associated with individuals with psychiatric disabilities that are engaged in employment. Rehabilitation interventions aimed at increasing levels of employment in people with psychiatric disabilities could improve recovery and employmentoutcomes through focusing on these personal variables. (Psychiatric Rehabilitation J. 2011 summer; 35(1):59-63.)

2.3.6. Study conducted by Tsai J.et al.,**(A Cross-Sectional Study of Recovery Training and Staff Attitudes in Four Community Mental Health Centers**), This study examined whether recovery-related trainings in community mental health centers is associated with differences in staff attitudes and reported organizational practices, A total of 318 staff members at four community mental health centers completed questionnaires about their recovery attitudes and trainings they had received in the past year, *Results* revealed that Compared to staff who had no recovery-related training in

the past year, staff who had at least one recovery-related training reported significantly higher consumer optimism and a greater agency recovery orientation towards consumers' life goals. The number of recovery-related trainings was significantly correlated with scores on personal optimism, consumer optimism, and agency recovery orientation towards consumers' life goals, the findings suggest recovery training is positively related to staff recovery attitudes and agency practices. Community mental health centers may benefit from a systematic approach to recovery training. Further research is needed to determine directionality of these relationships and to parse the mechanisms of action, (Psychiatric Rehabilitation J. 2011 Winter;34(3):186-93)

2.3.7. Study conducted byFukuiS.et al.,**(Effect of Wellness Recovery Action Plan (WRAP) Participation on Psychiatric Symptoms, Sense of Hope, and Recovery**), This study examined the effects of WRAP participation on psychiatric symptoms, hope, and recovery outcomes for people with severe and persistent mental illness, A quasi-experimental study, with an experimental (*n*=58) and a comparison (*n*=56) group was conducted. WRAP sessions (8-12 week) were facilitated by one staff person and one peer worker at five communities' mental health centers in a Midwestern state. The Modified Colorado Symptom Index, the State Hope Scale, and the Recovery Markers Questionnaire (RMQ) were employed at the first and last WRAP sessions, as well as six months following the intervention. Repeated measures analysis of covariance and planned comparisons before and after the intervention were conducted, Findings revealed statistically significant group intervention effects for symptoms and hope, but not for RMQ. Planned comparisons showed statistically significant improvements for the experimental group in psychiatric symptoms and hope after the intervention, while non-significant changes occurred in the comparison group,The study results offer promising evidence that WRAP participation has a positive effect on psychiatric symptoms and feelings of hopefulness. If recovery is the guiding vision for mental health system reform, the study results provide evidence that WRAP programming may warrant a place in the current array of services offered through the publicly funded mental health system, (Psychiatric Rehabilitation J. 2011 Winter;34(3):214-22).

2.3.8. Study conducted by R. StarninoV.et al.,**(Outcomes of an Illness Self-Management Group Using Wellness Recovery Action Planning**), The aim of this preliminary study was to examine the impact of participation in an illness self-

management recovery program (Wellness Recovery Action Planning—WRAP) on the ability of individuals with severe mental illnesses to achieve key recovery related outcomes, A total of 30 participants from three mental health centers were followed immediately before and after engaging in a 12-week WRAP program, Three paired sample t-tests were conducted to determine the effectiveness of WRAP on hope, recovery orientation, and level of symptoms. A significant positive time effect was found for hope and recovery orientation. Participants showed improvement in symptoms, but the change was slightly below statistical significance, these preliminary results offer promising evidence that the use of WRAP has a positive effect on self-reported hope and recovery-related attitudes, thereby providing an effective complement to current mental health treatment. (Psychiatric Rehabilitation J. 2010 summer; 34(1):57-60).

2.3.9. Study conducted by Judith A. Cook, Mary Ellen Copeland.et al., (**Results of a Randomized Controlled Trial of Mental Illness Self-management Using Wellness Recovery Action Planning**), The purpose of this study was to determine the efficacy of a peer-led illness self-management intervention called Wellness Recovery Action Planning (WRAP) by comparing it with usual care, A total of 519 adults with severe and persistent mental illness were recruited from outpatient community mental health settings in 6 Ohio communities and randomly assigned to the 8-week intervention or a wait-list control condition. Outcomes were assessed at end of treatment and at 6-month follow-up using an intent-to-treat mixed-effects random regression analysis. Compared to controls, at immediate post intervention and at 6-month follow-up, The primary outcome was reduction of psychiatric symptoms, with secondary outcomes of increased hopefulness, and enhanced quality of life (QOL). WRAP participants reported: (1) significantly greater reduction over time in Brief Symptom Inventory Global Symptom Severity and Positive Symptom Total, (2) significantly greater improvement over time in hopefulness as assessed by the Hope Scale total score and subscale for goal directed hopefulness, and (3) enhanced improvement over time in QOL as assessed by the World Health Organization Quality of Life-BREF environment subscale. These results indicate that peer-delivered mental illness self-management training reduces psychiatric symptoms, enhances participants' hopefulness, and improves their QOL over time. This confirms the importance of peer-led wellness management interventions, such as

WRAP, as part of a group of evidence-based recovery-oriented services. (Schizophrenia Bulletin Advance Access published March 14, 2011)

2.3.10. Study conducted by Judith A. Cook, Mary Ellen Copeland.et al., (**Developing the Evidence Base for Peer-Led Services: Changes among Participants following Wellness Recovery Action Planning (WRAP) Education in Two Statewide Initiatives**), The purpose of this analysis was to evaluate the outcomes of two statewide initiatives in Vermont and Minnesota, in which self-management of mental illness was taught by peers to people in mental health recovery using Wellness Recovery Action Planning (WRAP), Pre-post comparisons were made of reports from 381 participants (147 in Vermont and 234 in Minnesota) on a survey instrument that assessed three dimensions of self-management: 1) attitudes, such as hope for recovery and responsibility for one's own wellness; 2) knowledge, regarding topics such as early warning signs of decompensation and symptom triggers; and 3) skills, such as identification of a social support network and use of wellness tools, Significant positive changes in self-management attitudes, skills and behaviors were observed on 76% of items completed by Vermont participants (13 of 17 survey items), and 85% of items completed by Minnesota participants (11 of 13 items). In both states, participants reported significant increases in: 1) their hopefulness for their own recovery; 2) awareness of their own early warning signs of decompensation; 3) use of wellness tools in their daily routine; 4) awareness of their own symptom triggers; 5) having a crisis plan in place; 6) having a plan for dealing with symptoms; 7) having a social support system; and 8) ability to take responsibility for their own wellness, (Psychiatric Rehabilitation J. 2010 Autumn;34(2):113-20).

2.3.11. Study conducted by Grisly H. Gudjonsson,1 Gemma Webster,1 Timothy Green2 **(The recovery approach to care in psychiatricservices: staff attitudes before and after training),** the purpose of this study was to investigate the attitude of staff towards the recovery approachin forensic mental health services and the impact of training on staff knowledge andattitudes. A specially constructed 50-item recovery approach staff questionnaire, which focused on the core components of the recovery approach, was completed by137 members of staff in in-patient forensic services in Lambeth, south London.Results Staff were generally very positive about the implementation of the recoveryapproach in forensic services and those who had received training scored

significantlyhigher on the questionnaire than non-trained staff, (The Psychiatrist (2010) 34: 326-329)

2.3.12. Study conducted by Doughty C, Tse S, Duncan N, McIntyre L. **(The Wellness Recovery Action Plan (WRAP): workshop evaluation).** This study evaluated the delivery of a series of workshops on mental health recovery. The aims were to determine if the workshops changed participants' attitudes and knowledge about recovery, if there were any differences in views between consumers and health professionals of mental health services, and how the delivery and content of the program could be improved, A total of 187 consumers and health professionals from mental health services attended a workshop based on the Wellness Recovery Action Plan (WRAP). Questionnaires were administered before and after the workshop. Study revealed a significant change in total attitudes and knowledge about recovery ($p<0.001$) in the expected direction, with no differences between consumers and health professionals. The majority of participants found the workshop useful, and the majority of comments were positive. (Australas Psychiatry. 2008 Dec;16(6):4506)

2.3.13. Study conducted by Starnino VR, Mariscal S, Holter MC, Davidson LJ, Cook KS, Fukui S, Rapp CA, (**Outcomes of an illness self-management group using wellness recovery action planning**), The aim of this preliminary study was to examine the impact of participation in an illness self-management recovery program (Wellness Recovery Action Planning WRAP) on the ability of individuals with severe mental illnesses to achieve key recovery related outcomes. A total of 30 participants from three mental health centers were followed immediately before and after engaging in a 12-week WRAP program, Three paired sample t-tests were conducted to determine the effectiveness of WRAP on hope, recovery orientation, and level of symptoms. A significant positive time effect was found for hope and recovery orientation. Participants showed improvement in symptoms, but the change was slightly below statistical significance, (Psychiatric Rehabilitation J. 2010 summer; 34(1):57-60).

2.4 Summary of LR

From the previous study the researcher noted that studies focused in the same principle that underpin this study with the difference in the way of taking the sample

and the different variables of respondents. All of this study emphasis the important of consumer provider relationships, and the important role which played by mental health provider in the recovery process, and how can we with little effort improve the knowledge and attitude of provider towered recovery process, also the research confirmed the effectiveness of (WRAP), as a tools of mental health care, the researcher believe also on this option as a right one that consistent with our culture and believe system that respect the human kind.

CHAPTER THREE
METHODOLOGY

Chapter3

Methodology

3.1 Overview

This chapter presents issues and titles which related to methodology used by the researcher to provide answers to the research questions. This chapter contains the following heading, study design, period of study, place of study, study population, sample size and sampling methods, eligibility, validity and reliability, pilot study, ethical consideration, data collection and data analysis.

3.2 Study design

The evaluation employed a multi-method approach using quantitative and qualitative

Approaches, pre-post test and focus group interview.

3.3 Period of study

The study was conducted in the period between October 2011 and May 2012.

3.4 Place of study

The study was carried out in community mental health directorate In Gaza governorates, includes one hospital and six community mental health centers.

3.5 Study population

Table (3.1) Study population

Jobs	Number	percent
Psychologist	**24**	**51.1**
Social worker	**23**	**48.9**
Total	**47**	**100.0**

The study population includes all psychosocial workers in mental health directorate in Gaza governorate (Census sample); above table shows the distribution and

percentage of the psychosocial workers according to the job title, the researcher don't include nurses and doctors in this study to avoid bias in recording changes in attitude and knowledge because the nurse have previous education about recovery concept at master program haled in Islamic university, regarding doctors the work issues don't allow the doctors to participate in the program due to shortage in numbers.

3.6. Eligibility

3.6.1. Inclusion criteria

All psychosocial workers in governmental sector in Gaza governorates were included in the study.

3.6.2. Exclusion criteria

Part time employees.
Internship and volunteers.
Employees in long vacation or outside Gaza strip.
Nurses, doctors.

3.7. Ethical Consideration

Approval from community mental health directorate was obtained to conduct the study. The researcher was explained the purpose and objectives of the study to all participants. The participation in the study was optional and confidential. Neither name nor personal data were mentioned (anonymity). It seems you forget to modify the language from present to past tense

3.8. Data Collection and instrumentation

Data on the impact of the Recovery and WRAP facilitation programmes were collected using pre and post course questionnaires and focus group interview the researcher explained to the participant that they have to complete the questionnaire for tow time one before training and one post training. Questionnaires were completed by participants prior to starting the education programme (pre-course) and immediately after completion (post-course). The information gathered in these questionnaires

revolves around opinions on and knowledge of Recovery from mental health problems, also focus group interview for the evaluation of the training program were facilitated immediately on completion of the training.

3.8.1 Questionnaire:

The questionnaire was a self report, using likert scale. Duplication, double parallel and leading questions were avoided. High concern was given to be clear, easy language and it was formulated in Arabic language. The questionnaire was reviewed by a panel of experts to evaluate it from face and content validity and then the questionnaire translated into English language by two different institutions, to ensure reliability of the questionnaire, small scale reliability test was conducted to evaluate the ambiguity, length and misunderstanding of the questionnaire. The questionnaire was include 3 domains, first is demographic data, the second domain is recovery knowledge's, and the third one is attitude toward recovery.

3.8.2 Focus Group interview

Focus groups were held with the psychosocial workers seniors of the community mental health center of community mental health directorate whom completed program; the focus groups for the evaluation of the training program were facilitated immediately on completion of the training. Inaddition, to gain insight into the thinking involved in the development, the effectiveness and applicability of the program, focus group was completed with 8 out of the 47 members of the psychosocial worker. Focus group was facilitated by the researcher, the role of the researcher was primarily to ensure a flow of discussion and monitor the focus group.

3.8.3 Training program

The program was developed based on Wellness Recovery Action Plan, Interviews, literature review, and consultation with mental health professionals were used to develop this program. The program consisting of twelve sessions and the subject matter of the sessions included introduction into recovery, stress management, Hope,

Personal Responsibility, Education, Self-Advocacy, Support, content of wellness recovery Action Plan and practical application which include:
A Daily Maintenance Plan, Triggers identification, Early Warning Signs, Worsening Situation, Crisis Plan, Post Crisis Planning.

Different teaching methods were used in the session like lectures, brain storming, group work, role play, video tab and other things.

3.9. Validity of the questionnaire

To ensure the validity of the questionnaire, two statistical tests were applied. The first test is Criterion-related validity test (Spearman test) which measures the correlation coefficient between each paragraph in one field and the whole field. The second test is structure validity test (Spearman test) that used to test the validity of the questionnaire structure by testing the validity of each field and the validity of the whole questionnaire. It measures the correlation coefficient between one filed and all the fields of the questionnaire that have the same level of similar scale.

3.9.1. Structure Validity of each dimension and the whole of questionnaire

To test the appropriateness of data collection instrument, and standardize the suitable way for data collection, the researcher was conducted a pilot study concerning the instrument.

3.9.1.1 Pilot study

A pilot study concerning the instrument, consists of (9) questionnaires to get a clear feedback. The participants were selected randomly from all psychosocial workers. It was helped in estimation of the time needed to answer the questionnaire, then many changes were applied and the questionnaire was finalized, the researcher calculated the correlation between each statement and the dimension it belongs to. The results are illustrated in tables (3.2), (3.3).

Table (3.2): Correlation between each statement and knowledge

No.	Correlation value	No.	Correlation value
11	0.635 * *	19	0.744 **
12	0.526 **	20	0.363 **
13	0.608 **	21	0.213 //
14	0.650 **	22	0.399 **
15	0.555 **	23	0.360 **
16	0.662 **	24	0.429 **
17	0.390 **	25	0.475 **
18	0.482 **	26	0.528 **

** = significance at 0.01 // = not significant

Table (3.3): Correlation between each statement and attitudes

No.	Correlation value	No.	Correlation value
27	0.434 **	34	0.682 **
28	0.771 **	35	0.692 **
29	0.620 **	36	0.438 **
30	0.692 **	37	0.678 **
31	0.369 *	38	0.688 **
32	0.574 **	39	0.570 **
33	0.640 **	40	0.734 **

Table (3.2) and (3.3) clarifies the correlation coefficient for each filed and the whole questionnaire. The p-values (Sig.) are less than 0.05, so the correlation coefficients of all the fields are significant at $\alpha = 0.05$, so it can be said that the fields are valid to be measured what it was set for to achieve the main aim of the study**.**

3.10. Reliability of the Research

The reliability of an instrument is the degree of consistency which measures the attribute; it is supposed to be measuring (Polit & Hunger, 1985). The less variation an instrument produces in repeated measurements of an attribute, the higher its reliability. Reliability can be equated with the stability, consistency, or dependability of a measuring tool. The reliability of scale questions was tested immediately after data cleaning and it was improved by standardization of the instrument and its implementation, design of questionnaire manual and data re-entry.

Split-half:

Table (3.4): Correlation coefficient using split-half method

Dimension	No. of items	Correlation	Spearman-Brown equation	P value
Knowledge	16	0.795	0.886	0.000
Attitudes	14	0.709	0.830	0.000

table (3.4) show the correlation coefficient between the total scores of odd statements and the total score of even statements, and then the researcher used Spearman-Brown equation.

3.11. Response rate

From the total of 48 subjects, (47) subjects had responded and gave answers, the response rate was 97%.

3.12. Limitation of the study:

The limitation of the present study was.

- Attendance of psychosocial worker due to interruption of work time.
- Bureaucracy of managerial level.
- Shortage of the references, texts and relevant articles
- Funding of the training session.

3.13. Statistical Analysis

All participants were given a numeric code to aid matching of questionnaires. Quantitative data were entered into the Statistical Package for the Social Sciences version 16 (SPSS) for analysis. Both descriptive and inferential statistics were generated. Questionnaires that could not be matched were excluded from this analysis.

Chapter four

Results

4.1 Introduction

This chapter presenting the result and the finding according to the test retest analysis of the study and focus group discussion. The researcher was discussing the result and the finding of analysis in relation to research objective, and to answer the research question. Also the researcher gives interpretation of statistical analyses of the study finding.

4.2 characteristic of population

Table (4.1): Distribution of study participants according to demographic variables

Items	Frequency	%
Age in years		
23 – 29	26	55.3
30 – 36	13	27.7
37 – 45	8	17.0
Total	**47**	**100.0**
Gender		
Male	20	42.6
Female	27	57.4
Total	**47**	**100.0**
Place of residency (governorate)		
North	8	17.0
Gaza	20	42.6
Middle	9	19.1
Khanyounis	5	10.6
Rafah	5	10.6
Total	**47**	**100**
Marital status		
Single	14	29.8
Married	33	70.2
Total	**47**	**100.0**
Qualification		
Diploma	2	4.3
Bachelor	31	66.0
Postgraduate	14	29.8
Total	**47**	**100.0**
Years of experience		
1 – 5 years	42	89.4
6 – 10 years	5	10.6
Total	**47**	**100.0**
Place of work		
Psychiatric hospital	16	34.0
Rehabilitation directorate	7	14.9
Training directorate	1	2.1
Service directorate	23	48.9
Total	**47**	**100.0**
Profession		
Psychologist	24	51.1
Sociologist	23	48.9
Total	**47**	**100.0**

4.2.1 Gender

Table (4.2) Distribution of study population according to gender

Gender		
Male	20	42.6
Female	27	57.4
Total	**47**	**100.0**

Table (4.2) show the gender distribution that the male percentages 47.6 while the female percentage is 57.7%. this reflect that policy makers supporting women empowerment and gender respect in Palestinian society, and giving good opportunity in work filed for the female. This may also related to decrease culture constrains and barriers the facing female employment in Gaza strips.

4.2.2 Age:

Table (4.3) Distribution of study population according to age

Items	**Frequency**	**%**
Age in years		
23 – 29	26	55.3
30 – 36	13	27.7
37 – 45	8	17.0
Total	**47**	**100.0**

Table (4.3) show the Age distributions, range between 23 and 45 with mean 30, 7 years, and this distribution reflect most psychosocial worker are young and less expertise. On the other hand this training offered to these categories makes the program fruitful because they have long time before retirement.

4.2.3. Marital status:

Table (4.4) Distribution of study population according to marital

Items	Frequency	%
Marital status		
Single	14	29.8
Married	33	70.2
Total	**47**	**100.0**

Table (4.4) show The frequency distribution that the majority of the study population is married70.2% this result reflect Palestinian culture. The median age at first marriage for male about 24 years, while for female is about 19 years old (PCBS. 2007). The percentage of single employees is about 29.8%.

4.2.4.Job title:

Table (4.5) Distribution of study population according to marital status

Items	Frequency	%
Profession		
Psychologist	24	51.1
Sociologist	23	48.9
Total	**47**	**100.0**

The job title was divided into two groups, first psychologist. Second group was sociologists; the table shows that the psychologists were 51.1%, while sociologists were 48.9%.

4.2.5. Level of qualification:

Table (4.6): Distribution of study population according to the level of qualification

Qualification		
Diploma	2	4.3
Bachelor	31	66.0
Postgraduate	14	29.8
Total	**47**	**100.0**

Table (4.6) shows that Bachelor's degree is the largest qualification between psychosocial employments in community mental health directorate. The number of postgraduate diploma degree is very little.

4.2.6.Years of Experience:

Table (4.7): Distribution of study population according to years of experience

Years of experience		
1 – 5 years	42	89.4
6 – 10 years	5	10.6
Total	**47**	**100.0**

Table (4.7) show Years of experience ranges between one year and 10 years, with mean 5years.

The mean of the years of experience relatively low this may relate to short history of community mental health directorate at Gaza and internal conflict which lead to employ new workers.

4.2.7.Work Setting:

Table (4.8): Distribution of study population according to work setting

Place of work		
Psychiatric hospital	16	34.0
Rehabilitation directorate	7	14.9
Training directorate	1	2.1
Service directorate	23	48.9
Total	**47**	**100.0**

Table (4.8) show that the highest percentage of PS employees is working in service directorate 48.9%. These departments contain 6 community mental health centers, while the second highest percentage of employment 34.0% is working in psychiatric hospital.

4.2.8. Residency place:

Table (4.9) Distribution of study population according to residency place

Place of residency (governorate)		
North	8	17.0
Gaza	20	42.6
Middle	9	19.1
Khanyounis	5	10.6
Rafah	5	10.6
Total	**47**	**100**

Table (4.9) shows the distribution of psychosocial workers according to their residency. The highest percentage of PS employees from Gaza governorate, this related

to geographical location of community mental health directorate and psychiatric l hospital.

4.3 Data Analysis

4.3. Pre and post test intervention

This section reports the findings from the pre and post questionnaires for program. The impact of the program on participants'knowledge, attitudes are presented.also different affect of program related to sociodemogrphic data.

4.3.1 Knowledge about recovery process

To determine level of knowledge about recovery process, the researcher calculated the frequencies and percentage of respondents on the knowledge items in the pre-intervention and post-intervention stage, the result illustrated in tables (4.10) and (4.11).

Table (4.10): knowledge of respondents regarding recovery process (pre - intervention)

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
11	I believe I have sufficient knowledge on the subject of the psychological recovery of the psychiatric patient	6.4	36.2	27.7	29.8	0
12	I know the importance of the recovery process as a means that can help the patient to return to control over his life	25.5	59.6	8.5	6.4	0
13	I can distinguish between different cases of the psychiatric patient's	17.0	55.3	14.9	12.8	0
14	I believe in the importance of giving hope for the psychiatric patient's	42.6	51.1	4.3	2.1	0
15	I can help the psychiatric patient to recognize the strengths that he has	10.6	66.0	23.4	0	0
16	I know what are the means that can help the patient to engage in the process of recovery	6.4	25.5	46.8	19.1	2.1
17	I know the reasons for the success of the psychiatric patients in overcoming times of crisis	8.5	66.0	19.1	6.4	0
18	I know the reasons for the failure of the psychiatric patient to overcome the crisis	8.5	68.1	10.6	12.8	0

19	I know effective steps of recovery process	6.4	21.3	38.3	31.9	2.1
20	I think I need a training course on the process of recovery	74.5	19.1	6.4	0	0
21	I'm trying to identify all new in the field of rehabilitation of the psychiatric patient and Integrate him into the community	44.7	55.3	0	0	0
22	I know that good follow-up of the early warning signs of relapse help to protect the patient from the psychological setback	42.6	51.1	4.3	2.1	0
23	I believe the importance of encouraging mental patient to participate in the planning of the treatment process	57.4	36.2	4.3	2.1	0
24	I believe the importance of encouraging mental patient to make decisions concerning his personal life	42.6	53.2	2.1	2.1	0
25	I know that reducing the stigma associated with mental illness in the society is the most important tools that help the patient's in the recovery process	46.8	53.2	0	0	0
26	I know how I record stages of intervention with the patient progressively	6.4	34.0	48.9	10.6	0
	Mean percent	**27.93**	**46.95**	**16.22**	**8.63**	**0.26**

Table (4.11): knowledge of respondents regarding recovery process (post-intervention)

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
11	I believe I have sufficient knowledge on the subject of the psychological recovery of the psychiatric patient	46.8	53.2	0	0	0
12	I know the importance of the recovery process as a means that can help the patient to return to control over his life	85.1	14.9	0	0	0
13	I can distinguish between different cases of the psychiatric patient's	34.0	59.6	4.3	2.1	0
14	I believe in the importance of giving hope for the psychiatric patient's	91.5	8.5	0	0	0

15	I can help the psychiatric patient to recognize the strengths that he has	70.2	29.8	0	0	0
16	I know what are the means that can help the patient to engage in the process of recovery	63.8	36.2	0	0	0
17	I know the reasons for the success of the psychiatric patients in overcoming times of crisis	63.8	36.2	0	0	0
18	I know the reasons for the failure of the psychiatric patient to overcome the crisis	61.7	34.0	2.1	2.1	0
19	I know effective steps of recovery process	61.7	31.9	6.4	0	0
20	I think I need a training course on the process of recovery	19.1	29.8	38.3	12.8	0
21	I'm trying to identify all new in the field of rehabilitation of the psychiatric patient and Integrate him into the community	40.4	57.4	0	2.1	0
22	I know that good follow-up of the early warning signs of relapse help to protect the patient from the psychological setback	93.6	6.4	0	0	0
23	I believe the importance of encouraging mental patient to participate in the planning of the treatment process	91.5	6.4	2.1	0	0
24	I believe the importance of encouraging mental patient to make decisions concerning his personal life	61.7	38.3	0	0	0
25	I know that reducing the stigma associated with mental illness in the society is the most important tools that help the patient's in the recovery process	85.1	10.6	4.3	0	0
26	I know how I record stages of intervention with the patient progressively	21.3	74.5	4.3	0	0
	Mean percent	**61.95**	**32.98**	**3.86**	**1.19**	**0**

4.3.2 Self-Rating Knowledge Questions

Research objective: To assess differences in knowledge among psychosocial workers about recovery process before and after the training program.

Main Finding: Participants rated their knowledge of WRAP and Recovery after the program as higher than before. This increase in self-reported knowledge of both WRAP and Recovery was statistically significant. Participants were asked to rate their knowledge of Recovery and their knowledge of WRAP on 15 - point scales, Prior to the training program.A paired samples t-test comparing the pre and post means for the program resulted in statistically significant increases for both self-reported knowledge of Recovery and WRAP, pre- intervention (m = 62.978) , post- intervention (m =72.914), mean differences was (-9.936) and t value was (-12.163), Figure (4.1) and Table (4.12) show a summary of these results.

Table (4.12): Differences in knowledge about recovery process (pre and post intervention)

Onset	N	Mean	S. deviation	Mean difference	t	P value
Pre-intervention	47	62.978	5.573	- 9.936	- 12.163	0.000 *
Post-intervention	47	72.914	3.866			

- = significant at 0.05

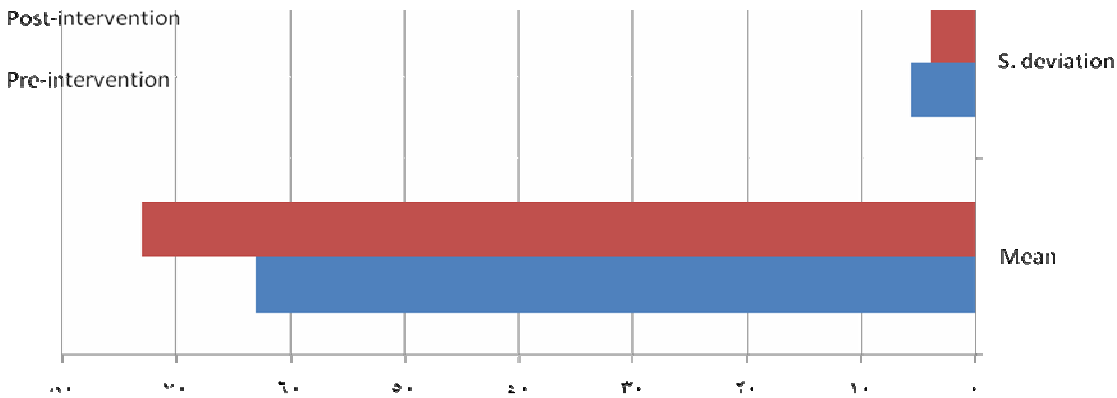

Figure (4.1): Comparison of mean scores on Recovery Knowledge questions (RKQs), pre- and post-participation in program

4.3.3 Attitudes toward recovery process

To estimate attitude toward recovery process, the researcher calculated the frequencies and percentage of respondents on the attitude items in the pre-intervention and post-intervention stage the result illustrated in tables (4.13) and (4.14).

Table (4.13): Attitudes of respondents regarding recovery process (pre-intervention)

No	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
27	Recovery (wellness) from mental illness is something possible, regardless of the cause of the disease	25.5	48.9	21.3	4.3	0
28	The correct understanding of mental illness help in recovery from it	36.2	59.6	4.3	0	0
29	To recover you need the faith	36.2	57.4	6.4	0	0
30	The recovery could happen even with the presence of symptoms	8.5	46.8	29.8	14.9	0
31	People in recovery is sometimes exposed to relapse	29.8	40.4	29.8	0	0
32	The peopledifferin the ways oftheir recoveryfrommental illness	27.7	61.7	6.4	2.1	2.1
33	Recovery frommental illnesscan be doneevenwithout the help ofprofessionals in thefield of mental health	2.1	10.6	21.3	48.9	17.0
34	All the people whosuffer fromseveremental illnesscan succeed inrecovery	0	17.0	44.7	31.9	6.4
35	Peoplerecovering frommental illnesswho are notmentally illin the first place	4.3	34.0	25.5	25.5	10.6
36	The recovery processneedfor hope	46.8	48.9	2.1	2.1	0
37	Stigma associated withmental illnesscan hinderthe recovery process	34.0	51.1	10.6	4.3	0
38	The recoveryfrom the consequences ofmental illnesssometimesbe harderthan the recovery from the disease itself	12.8	61.7	19.1	6.4	0
39	Familymay needto recover fromthe impact of mental disorder of one of its members	27.7	53.2	17.0	2.1	0
40	Psychiatric patientwill needhospitalizationagainin the future	2.1	44.7	25.5	25.5	2.1
	Mean percent	**20.97**	**45.42**	**18.84**	**12.0**	**2.72**

Table (4.14): Attitudes of respondents regarding recovery process (post-intervention)

No.	Item	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
27	Recovery (wellness) from mental illness is something possible, regardless of the cause of the disease	46.8	53.2	0	0	0
28	The correct understanding of mental illness help in recovery from it	83.0	17.0	0	0	0
29	To recover you need the faith	89.4	10.6	0	0	0
30	The recovery could happen even with the presence of symptoms	55.3	38.3	4.3	2.1	0
31	People in recovery is sometimes exposed to relapse	42.6	55.3	2.1	0	0
32	The peopledifferin the ways oftheir recoveryfrommental illness	80.9	19.1	0	0	0
33	Recovery frommental illnesscan be doneevenwithout the help ofprofessionals in thefield of mental health	34.0	46.8	8.5	10.6	0
34	All the people whosuffer fromseveremental illnesscan succeed inrecovery	14.9	66.0	10.6	8.5	0
35	Peoplerecovering frommental illnesswho are notmentally illin the first place	36.2	40.4	10.6	8.5	4.3
36	The recovery processneedfor hope	91.5	6.4	2.1	0	0
37	Stigma associated withmental illnesscan hinderthe recovery process	80.9	19.1	0	0	0
38	The recoveryfrom the consequences ofmental illnesssometimesbe harderthan the recovery from the disease itself	78.7	17.0	4.3	0	0
39	Familymay needto recover fromthe impact of mental disorder of one of its members	76.6	21.3	2.1	0	0
40	Psychiatric patientwill needhospitalizationagainin the future	8.5	48.9	19.1	23.4	0
	Mean percent	**58.52**	**32.81**	**4.55**	**3.79**	**0.30**

4.3.4 Recovery Attitudes Questions (RAQ)

Research objective: To assess differences in attitude among psychosocial workers towered recovery process before and after the training program.

Main Finding: Participants showed positive attitudes towards the principles of Recovery as measured with the Recovery Attitudes Questions (RAQ) before participating in the program, and demonstrated more positive attitudes towards recovery principles after the training program. Using the RAQ, participants were asked to rate their agreement with fourteen statements on Recovery, on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). The total score for the RAQ is the sum of the scores on the fourteen questions. With aminimal score of 1 and a maximum of 5 for each item.

Results suggest that participants' attitudes towards Recovery principles were positive to start with a mean of RAQ score of 51.787 (SD = 4.318). This increased to 62.361 (SD = 5.264) post the program. Although the increase in participants' attitudes supporting recovery principles was good, a paired sample t-test of the pre and post means for the program yielded statistically significant results (t = -11.809, p = 0.000).. Figure 4 and Table (4.15) provide a summary of these results. The results showed that there were statistically significant differences at 0.05 in attitudes toward recovery process between the two stages; pre-intervention (m = 51.787) and post intervention (m = 62.361), mean difference was (- 10.574) and t value was (- 11.809). This result means that attitudes post-intervention were higher than pre-intervention; the result illustrated in tables (4.15) & figure (4.2).

Table (4.15): Differences in attitudes toward recovery process (pre and post intervention)

Onset	N	Mean	S. deviation	Mean difference	T	P value
Pre-intervention	47	51.787	4.318	- 10.574	- 11.809	0.000 *
Post-intervention	47	62.361	5.264			

* = significant at 0.05

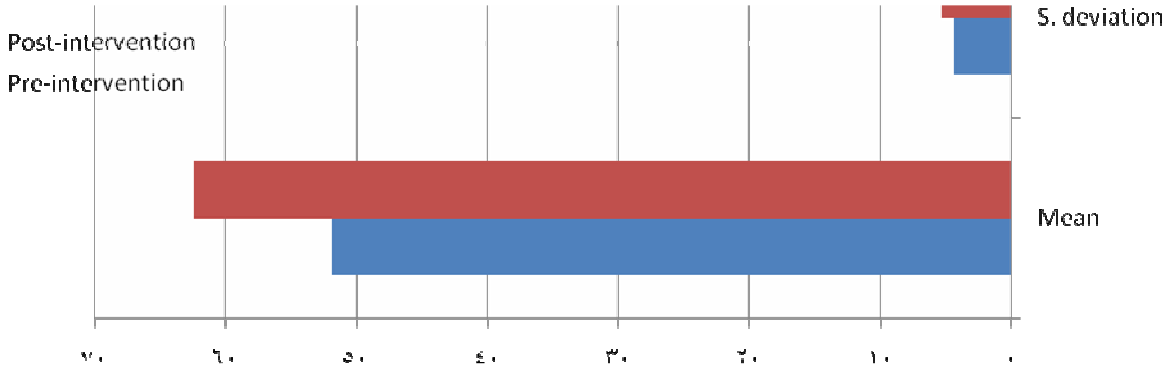

Figure (4.2): Comparison of mean scores on Recovery attitude questions (RAQs), pre- and post-participation in program

4.3.5 Impact of Self-Description, Age, Gender, and Location and level of qualification

Research objective: To ascertain whether an association exist between knowledge and attitude in relation to socio-demographic characteristics (age, gender, level of educations).

Main finding: The predominant result is that there are no major differences between different groups of participants in the impact that the program had and the way in which it was evaluated. It is important to establish whether the program were more or less effective for one group of participants over another. Of particular interest were possible differences between (a) younger and older participants (Age) , (b) men and women (gender), (c) participants in the different locations (area of living) , and (d) level of qualification. To establish whether differences occurred in the impact of the program on these different groups, Analyses of Variance were performed for the main variables addressed in this chapter. To provide a representation of the overall impact of the program on the learning experience of the participants, the following procedurewas followed. Where the questions had been presented in a scale or a thematic cluster the summated total score for all questions in the scale or cluster was used. Analyses of Variance were performed over the differences between pre and post.

Results showed foremost that effects for the three factors do not play asignificant part in the responses to the questionnaires pre and post participation in the programs, revealed that no effects for age and gender effect is found, only for qualification with the process before the program.

4.3.6 Gender

4.3.6.1 Gender & knowledge

Table (4.16): Differences in knowledge about recovery process related to gender

Onset	Gender	N	Mean	S. deviation	T	P value
Pre-intervention	Male	20	63.500	6.468	0.548	0.587 //
	Female	27	62.592	4.901		
Post-intervention	Male	20	73.700	3.988	1.204	0.235 //
	Female	27	72.333	3.741		

// = not significant

Table (4. 18) showed that there were no statistically significant differences in knowledge about recovery process between male and female participants; t value was 0.548 at pre-intervention stage and t value was 1.204 at post-intervention stage. The result illustrated in tables (4.16), figures(4.3).

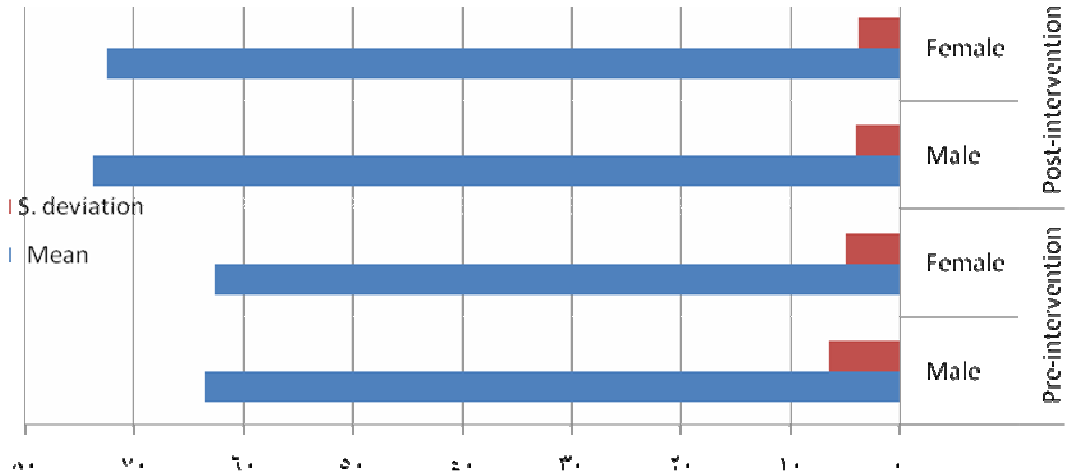

Figure (4.3): Comparison of mean scores and stander deviation on Recovery knowledge question (RKQs) related to gender, pre- and post-participation in program.

4.3.6.2 Gender &Attitude

Table (4.17): Differences in attitudes toward recovery process related to gender

Onset	Gender	N	Mean	S. deviation	t	P value
Pre-intervention	Male	20	51.900	4.722	0.152	0.880 //
	Female	27	51.703	4.083		
Post-intervention	Male	20	63.350	6.106	1.110	0.273 //
	Female	27	61.629	4.524		

// = not significant

Table (4.17) show that there were no statistically significant differences in attitudes toward recovery process between male and female participants; t value was 0.152 at pre-intervention stage and t value was 1.110 at post-intervention stage, The result illustrated in tables (4.17), figures (4.4).

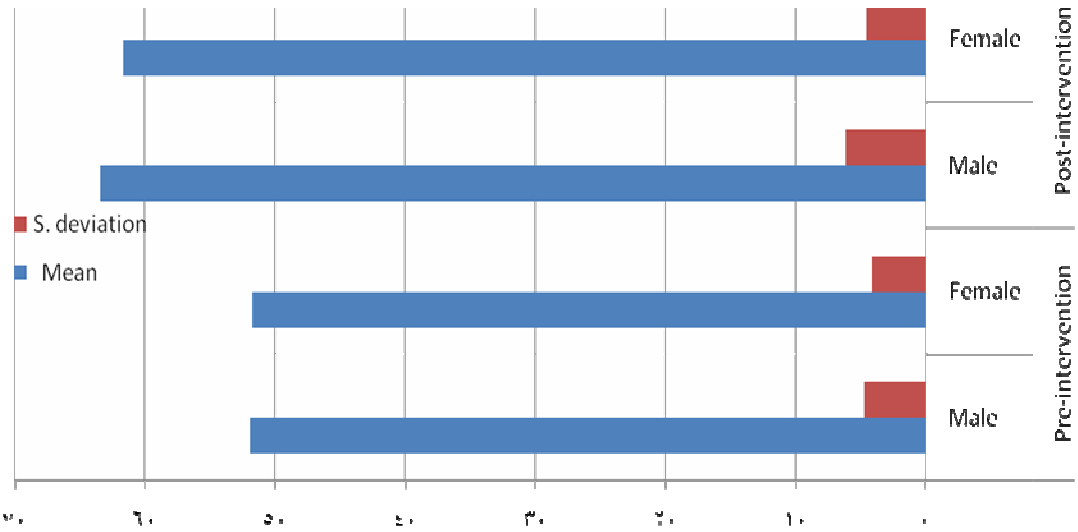

Figure (4.4): Comparison of mean scores and stander deviation on Recovery Attitude Questions (RAQs) related to gender, pre- and post-participation in program.

4.3.7 Age

4.3.7.1 Age and knowledge

Table (4.18): Differences in knowledge related to age

Onset	Category	Some of squares	df	Mean square	F	*P*
Pre-intervention	Between groups	11.902	2	5.951	0.185	0.832 //
	Within groups	1417.077	44	32.206		
	Total	1428.979	46			
Post-intervention	Between groups	15.361	2	7.681	0.503	0.608 //
	Within groups	672.298	44	15.280		
	Total	687.660	46			

// = not significant

Table (4.19) show that There were no significant differences in knowledge about recovery process in pre-intervention (F= 0.185) and post-intervention (F= 0.503) related to age, the result illustrated in tables (4.18), figures (4.5).

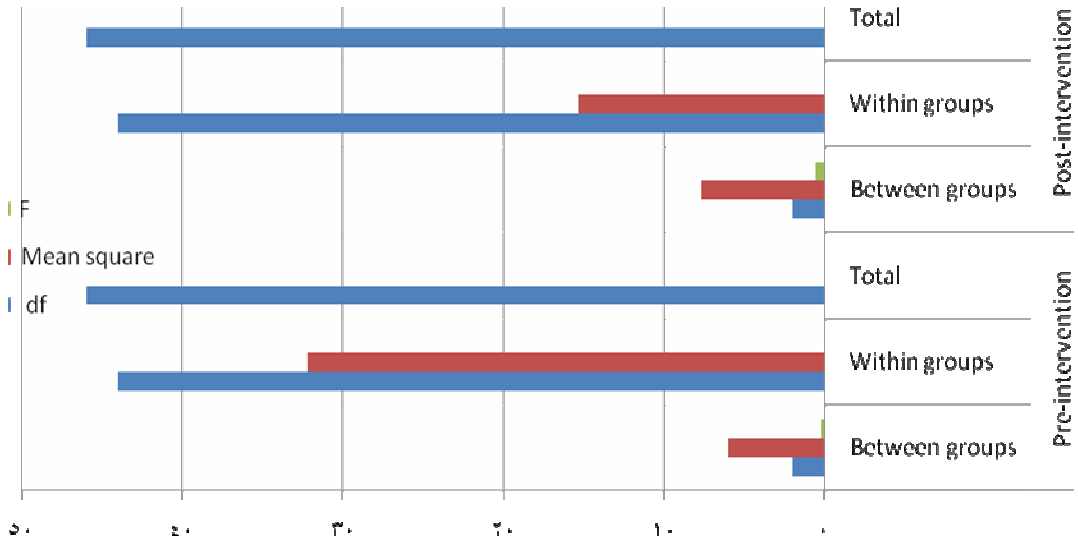

Figure (4.5): Comparison of mean scores and stander deviation on Recovery Knowledge Questions (RKQs) related to Age, pre- and post-participation in program**.**

4.3.7.2 Age and Attitude

Table (4.19): Differences in attitudes related to age

Onset	Category	Some of squares	df	Mean square	F	*P*
Pre-intervention	Between groups	17.411	2	8.705	0.456	0.637 //
	Within groups	840.462	44	19.101		
	Total	857.872	46			
Post-intervention	Between groups	95.197	2	47.599	1.775	0.181 //
	Within groups	1179.654	44	26.810		
	Total	1274.851	46			

// = not significant

Table (4.19) show that There were no significant differences in attitudes toward recovery process in pre-intervention (F= 0.456) and post-intervention (F= 1.775) related to age, the result illustrated in tables (4.18), figures (4.5).

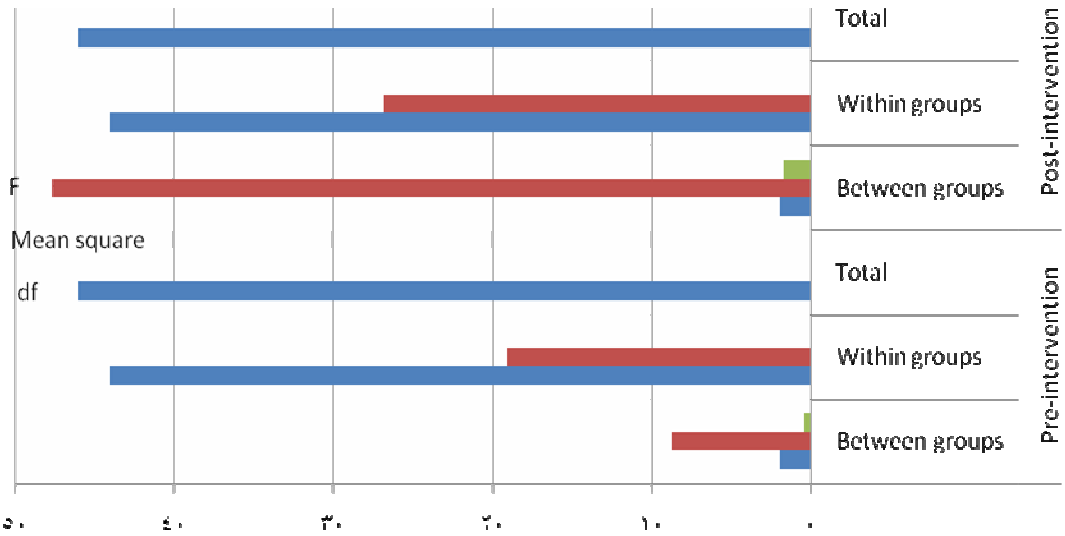

Figure (4.6): Comparison of mean scores and stander deviation on Recovery Attitude Questions (RAQs) related to Age, pre- and post-participation in program**.**

4.3.8. Qualification

4.3.8.1 Qualification& knowledge

Table (4.20): Differences in knowledge related to qualification

Onset	Age years	Some of squares	df	Mean square	F	*P*
Pre-intervention	Between groups	335.163	2	167.582	6.741	0.003 *
	Within groups	1093.816	44	24.859		
	Total	1428.979	46			
Post-intervention	Between groups	12.183	2	6.091	0.397	0.675 //
	Within groups	675.477	44	15.352		
	Total	687.660	46			

* = significant at 0.05 // = not significant

Table (4.20) show that There was statistically significant differences at 0.05 in knowledge about recovery process in pre-intervention related to qualification (F= 6.741) and P value was 0.003, but differences were not significant in the post-intervention stage (F= 0.397) and P value was 0.675, the result illustrated in tables (4.120).

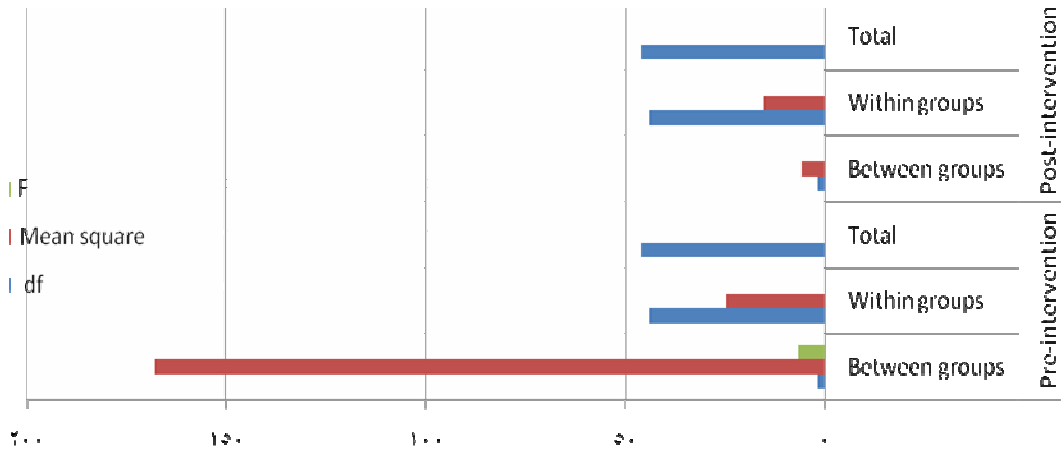

Figure (4.6): Comparison of mean scores and stander deviation on Recovery Attitude Questions (RAQs) related to Age, pre- and post-participation in program.

To know the direction of the differences in knowledge at pre-intervention stage, Post hoc Scheffe test was performed.

Table (4.21): Mean differences in knowledge related to qualification

	Qualification	Mean difference	*P* value
Knowledge Pre-intervention	(postgraduate diploma) – (bachelor)	10.709	0.019 *
	(master degree) – (bachelor)	4.138	0.045 *

* = significant at 0.05

Table (4.21) shows that psychologists and sociologists who have postgraduate diploma have higher knowledge than those who have bachelor degree, mean difference was 10.709 and P value was 0.019. Also, those who have master degree have higher knowledge than those who have bachelor degree, mean difference was 4.138 and P value was 0.045. This means that those who have bachelor degree have lower knowledge compared to those who have diploma or postgraduate studies**.**

4.3.8.2 Qualification and Attitude

Table (4. 22): Differences in attitudes related to qualification

Onset	category	Some of squares	df	Mean square	F	*P*
Pre-intervention	Between groups	37.965	2	18.982	1.019	0.369 //
	Within groups	819.908	44	18.634		
	Total	857.872	46			
Post-intervention	Between groups	4.326	2	2.163	0.075	0.928 //
	Within groups	1270.525	44	28.876		
	Total	1274.851	46			

// = not significant

Tables (4. 22) show that there were no significant differences in attitudes toward recovery process in pre-intervention (F= 1.019), P value was 0.369 and post-intervention (F= 0.075), P value was 0.928 related to qualification.

Qualitative Analysis

4.4 Findings from the Focus Groups

This section presents the emerging themes from the focus groups held with the participants of program; the findings from the analysis are presented under the following themes:

• Recovery and WRAP: An inspiring and active experience that is totally suitable for our culture and agreed with our religion direction.
• Recovery and WRAP: Shifting the paradigm of mental health care.
• Putting Recovery and WRAP into Practice: A simple and practical tool kit.
• Structure and Delivery of the Program: Mixed reactions.
• Mainstreaming Recovery and WRAP: Obstacles and concerns.

4.4.1 Recovery and WRAP: An inspiring and active experience

Participants described the program in a positive way and spoke of it as being an inspiring, invigorating and life changing experience that promoted self confidence and have culture and religious sense.

"For me this has been the most amazing, beneficial personal experience that meet our culture value and system" (S.A).
"For me it has just been a life experience that I could never praise enough that give us chance to show life for our client in different way really it's amazing" (N.A).

The above comments were also strongly reflected in the qualitative comments made by participants at the end of the questionnaires. Participants attributed many of the positive outcomes to the level of interaction, engagement and personal disclosure that was fostered throughout the days. In particular, participants valued how the values of recovery were modeled by the researcher, from the outset, and integrated throughout the program.

"I felt that the whole philosophy of recovery was embodied from day one, from the researcher to everyone" (I.H).

Having time to agree boundaries and values was welcomed by several participants and identified as important in creating trust and safety within the groups. This level of trust enabled participants to speak openly and honestly about their experiences.

Participants welcomed and valued the opportunity to share their own story and hear other peoples' stories and experience. Listening to peoples' stories in an environment that was nonjudgmentaland supportive acted as an enabling medium, facilitating some participants to talk about some cases , the researcher start by talking about special experience with cases of depressive patients that researcher work with during the application of WRAP on qualitative research which were held during the last semester in master program of community mental health nursing at Islamic university which conducted by Dr, Yossif Aljeesh and the researcher .

Sharing personal experiences was also considered an important means of validation. Using personal experiences to help others appeared to heighten participants' sense of achievement and personal satisfaction. For many, this was the first time their personal experience was acknowledged as a valuable source of learning and help for others.

"I work with mental health services, this program is a kind of facilitation based on a value of personal experience and that has been most beneficial" (K.H)

4.4.2 Recovery and WRAP: Shifting the paradigm of mental health care

The concepts of Recovery and WRAP were initially unfamiliar to a number of the participants the two concepts are a move away from the medical and illness paradigms that tend to dominate mental health care. Prior to attending the program, some participants viewed recovery in a traditional "medical" manner, seeing it as the absence of symptoms, or as illness remission. Attending the program exposed the participants to new ways of thinking about Recovery. Specifically, the emphasis on taking greater control of one's own destiny,through accepting greater levels of self responsibility, was embraced and viewed as the foundation of Recovery and the WRAP

approach. This focus on self help, self management, and taking responsibility was perceived by the participants to be empowering, refreshing and positive.

"What WRAP does is empowers people …it gives them a voice to do their choice" (N.S).

"This allows people to be empowered to take control, and tell others what they want" (S.K).
"It gave me power to help myself, and others" (K.H).

"WRAP means you are responsible for yourself" (S.A).

The shift in emphasis from an illness model to the promotion and nurturing of positivemental health was viewed by participants as a core message of Recovery.

"The focus was more positive, it was more focused on getting well rather than the sickness" (K.H).

"It was just completely different [from hospital], the focus was more positive" (S.H).

The focus on wellness and not just illness also offered a sense of hope to many participants.

"I would have felt that WRAP was more positive …Just the basic words that would have been used, you know like hope and words like that" (N.S).

"It gives people hope and gives you hope in your work. It's like a vision for afuture" (K.H).

Learning about recovery and WRAP challenged the assumption that those with self experience of mental distress are (or perhaps should be) passive recipients of mental health care. A number of participants contrasted the active and participative message of Recovery with their experience of traditional mental health services where people are treated as passive recipients within their own recovery journey.

"It was just completely different…. From the day hospital, …the emphasis is more medication and once you're doing that [taking medication]everything else was fine, it didn't matter what else you did" (S.H).

"WRAP is giving you the control you know; you decide how to live your life and whatever."(S.K).

4.4.3 Putting Recovery and WRAP into Practice: A simple and practical toolkit

Participants expressed enthusiastic views concerning their use of WRAP and thebenefits they had achieved personally, professionally and within their broader socialcircle as a result of their participation in the program at each level. There was astrong sense that the participants valued the WRAP approach because of its simplicityand practicality. In essence, the WRAP approach was experienced as a systematic andstructured self management approach which helped participants make sense ofexperiences as well as normalizing distress. Participants spoke of WRAP as a simpleand practical toolkit that placed a certain structure or order on what many were doingalready to cope with distress and manage their health. The structure of the WRAPapproach was perceived as one which made eminent common sense, was logical andachievable. Many participants, both people with self experience and practitioners,spoke of the accessibility of the language of recovery and WRAP, which they foundhelpful.

4.4.4 Structure and Delivery of the Program: Mixed reactions

In terms of the course structure and delivery, several participants stated that therewas a good balance between the theory of Recovery and WRAP and putting it intopractice. Although the course addressed a lot of information, participants did not feeloverloaded or that the content was too technical. For many, the length of timeallocated to the program was "just right". Others, however, thought thatthey needed more time to complete their Wellness Recovery Action Plans and getother peoples' perspectives and feedback. For someparticipants the group size was "too big" and restricted the amount of time availablefor discussion; as stated by one participant:

"I think [the group was] far too big. You ended up sticking to your own grouptoo much; I think a smaller group would have allowed freer discussion andmuch more time for it" (N.s).

Although the participants believed that having a smaller group would facilitate freerdiscussion as well as more time to accommodate the diversity of opinions within thegroup, they appreciated the external pressures the researcher were under to meet the work condition. The length of the program alsoevoked different responses; some participants suggested that the length of the program be extended to seven days, however others believed that five days wassufficient.

4.4.5 Mainstreaming Recovery and WRAP: Obstacles and concerns

This theme presents the perceived obstacles and concerns that the participants believed might impact negatively on the future of Recovery andWRAP. These revolved around personal confidence, current philosophy of services,leadership, maintaining the philosophy of recovery and WRAP, and burdening peoplewith self experience.Although many of the participants were very positive about passing on themessage of recovery and WRAP, and believed that they could pass on the concepts topeople in an informal way, they questioned whether they had the requisite skills tocommunicate the essential components of Recovery and WRAP in a formal educationcontext., and many feltempowered "to go out and help other people". However, some expressed a lack ofconfidence about facilitating a recovery and WRAP program. Despite this, many acknowledged it would take time to gain experience in delivering the program and that their confidence was likely to increase with time andexperience.

"We have got the tools really; we have got the tools… [But]...I will not be Comfortable with it until I have delivered it a few times" (N.S).

4.4.6 Summary

Overall, participants spoke very positively and were enthusiastic about the benefits they had achieved personally, professionally and within their broader social circle as aresult of their participation in the program. Participants described their experienceas inspiring, invigorating and life changing. The program was viewed as an empowering experience in that it promoted a sense of self belief and capacity forwellness and recovery among all participants and was instrumental in sending out amessage that people can live well with and recover from mental illness. Prior to attending the program, some participants viewed Recovery in a traditionalmedical manner, seeing it as the absence of symptoms, or as illness remission.

Attending the program exposed the participants to new ways of thinking about Recovery. Participants left the program with a great sense of optimism about the concepts underpinning Recovery and WRAP and with clear messages of hope and personal validation. The program clearly impacted on all participants' belief in the capacity for wellness and recovery.The emphasis within the program on wellness, positive mental health and recovery were viewed as a positive move away from the dominant medical and illness paradigms. The focus on self help, self management, and taking responsibility and control was perceived by the participants to be empowering, refreshing and positive. Learning about Recovery and WRAP challenged the assumption that those with self experience of mental distress are passive recipients of mental health care. It also helped the participants to think differently about themselves and view mental distressas a normal reaction to life's challenges. Participants described how the program shifted their mind set and enabled them to open up a different dialogue with themselves and others, around recovery and wellness.

In terms of the course structure and delivery, several participants stated that there was a good balance between the theory of Recovery and WRAP and putting it into practice. Some were of the view that they needed more time to complete their Wellness Recovery Action Plans and get other peoples' perspectives and feedback. Others believed that a smaller group size would have made more time available for discussion. Although many of the participants were very positive about passing on the message of Recovery and WRAP, and believed that they could pass on the concepts to people in an

informal way, they questioned whether they had the requisite skills to communicate the essential components of recovery and WRAP in a formal education context, throughout the mental health services in Palestine, they did identify a number of barriers. Participants perceived that a major challenge to developing a recovery oriented service was overcoming the traditional biomedical approach, and shifting the philosophy of care from the present preoccupation with illness to one of wellness.

Chapter five

Discussions

5. Discussion

The aim of the study was to evaluate the impact of Mental Health Recovery and Wellness Recovery Action Planning (WRAP) program on participants' knowledge, Attitudes and skills of mental health Recovery and the WRAP approach. The objectives of the study were:

- To evaluate participants' attitudes, knowledge and skills regarding Mental Health Recovery and WRAP education program pre and post program delivery.
- To ascertain whether an association exist between knowledge and attitude in relation to socio-demographic characteristics (age, gender, level of education).
- To suggest recommendation to policy and decision makers regarding the opportunity to improve mental health condition in Gaza strip by applying recovery principles.

The study involved all psychosocial workers of community mental health general directorate, and used a qualitative and quantitative design (pre and post test design with focus groups interviews). Overall, the program was evaluated very positively by participants. Participants expressed very positive views about the benefits they had achieved personally, professionally and within their broader social circle and viewed the program as an empowering experience.

Findings indicated that the program impacted positively on participants' Knowledge and attitudes about Recovery and WRAP, in line with the changes reported by others who have evaluated Recovery and WRAP education programs (Grisly H, Gudjonsson,1, Gemma Webster,1 Timothy Green2 et al).

Although findings from the quantitative measures indicated that participants had increase in knowledge of WRAP and Recovery post participation, and held positive attitudes toward Recovery and WRAP. Results were consistently statistically significant on all measures for the participants; Quantitative findings also indicated that there were increases in participants' self rated ability to manage their client mental health and Recovery. These findings were supported by qualitative finding within the focus group interviews, with participants expressing positive views about the WRAP structure and welcoming the simplicity of its approach and language. They reported a

greater awareness and ability to manage and help client to cope with negative experiences, including increased awareness of factors/triggers that influence stress levels and ability to access recovery resources. Participants also reported learning new techniques and strategies to promote their own recovery as practitioner. Similar positive outcomes have been reported in other study. These included a significant perceived increase in knowledge of tools for coping with early warning signs and distress; increased understanding of how to create a crisis plan/WRAP, express needs and wishes, and explain early warning signs; and finding it easier to engage in recovery-promoting activities.

In addition to enhancing the participants' ability to manage their client mental health, both the quantitative and qualitative findings indicated that the program increased participants' confidence to help another person to develop his/her own WRAP plan and provide support. Similarly, in Doughty et al.'s (2008) study, the majority of participants reported that the program had impacted positively on their ability to facilitate another person to develop a WRAP.

Among the factors identified by people with self experiences as important for recovery is optimism about recovery, finding hope and taking personal responsibility (Andresen et al., 2003, Young and Ensing, 1999).

Recovery is not something that practitioners can do to a person; it is something that people do for themselves (Anthony, 1993), and this was strongly endorsed by the participants in this study who spoke of the role and challenge of personal responsibility in Recovery. Practitioners, however, can have a positive impact on possibility and potential by creating a positive and enriching environment. Central to this is practitioners having a hope and a belief in the possibility of Recovery (Higgins, 2008). practitioners reported leaving the program with a greater sense of hope, a belief in the capacity for their own and others' wellness and recovery, a greater belief in the importance of people being enabled to take control of the own lives and recovery, and a greater sense of empowerment and agency. Participants clearly welcomed the focus on personal responsibility, self help and self management, supporting Bryue et al 1994 view that WRAP as a tool has the potential to build on principles like hope, empowerment, responsibility and self help.

The content of the program in this study was similar to other education programs documented in the literature, although there was a concerted effort made by the researcher to move away from the medicalization of Recovery and WRAP, hence the language of diagnosis, symptom, relapse and compliance was avoided and WRAP was spoken of as a "life plan" for all as opposed to an "illness recovery plan".

Francisco (2006) pointed out that recovering from stigma can often be more challenging than recovering from the consequences of a mental health problems, from my experience I'm totally agreed with this point that in many cases we faced in practice you can see that the effect of stigma issues have more burden on the client's life, on this study in pre and post test most of participants strongly agree with this point as indicated in pre and post test result, The emphasis within the program on wellness, positive mental health and the message that people can live with and recover from mental illness were viewed as a positive move away from the dominant medical and illness paradigms and a powerful destigmatizing message, which needed to be communicated widely.

Similar to other program evaluated, participants were highly satisfied with the content and delivery of the program, with an overwhelming majority agreeing or strongly agreeing that they would recommend the course to others, this appear clearly in sum of call I receive from mental health professionals in different sitting in mental health general directorate when I stop the program for a period of time for other groups due work issues.

Some difficulties and challenges were highlighted. The difficulties with WRAP mainly consisted of the personal time required to complete it and the impact of people's distress on their ability to work through a WRAP. Similar challenges have also been documented previously, as well as concerns around the impact of heavy case loads and heavy administrative tasks on practitioners' time to facilitate the people to develop a WRAP (Culloty, 2005). There were mixed views around duration, with some psychosocial workers who completed the program wanting more time.

One of the main objectives of the program was to develop psychosocial skills in Facilitating Recovery and WRAP program. Comparison of reported knowledge and

attitudes before and after the program showed statistically significant increases in participants' perceptions of their ability to teach and facilitate the principles underpinning Recovery and WRAP. Those areas that participants perceived that they had become most skilled at facilitating after the program were Wellness Recovery Action Planning, Self Advocacy/Self Agency and Crisis/Post Crisis Planning. The greatest increases in facilitation skills came in Hope, Wellness Tools, and Values Based Care. Those areas that participants perceived that they were least skilled at facilitating after the program were the Role of Personal Responsibility in Recovery and Advance Agreements. However, the increase in reported skill in teaching and facilitation did not transfer to all participants' confidence to do so. Within the focus groups, participants, especially those who had little experience, expressed a lack of confidence in their ability. Indeed, expecting a more positive outcome may have been over aspirational on the psychosocial workers behalf, as the development of facilitation and teaching skills requires time, practice, support and reflection. What is important as an outcome in this study is the overwhelming desire of all the participants to become involved in spreading the message of Recovery and WRAP.

Tsai J. et al in their study reported some differences in attitudes to Recovery among the various groups included in their study. However, in this study and similarly to Doughty et al.'s (2008) study, there were no significant differences in quantitative outcomes between people in different group related to (age, level of education, place of residency).

Recovery knowledge and showed positive attitudes towards the concept and its implementation before participating in the program. This suggests that they had been exposed to some from of training specially for psychologists who attended postgraduate diploma in Islamic university, on the other hand the equal result for both whom previously have knowledge in recovery and those who haven't post program indicate that the program have good effect on both groups.

The Recovery vision cannot be realized without significant changes to professional practice, social attitudes, public discourses, cultural norms and assumptions, and economic and social structures. Participants in this study were indeed mindful of this and expressed concern about the lack of a national strategy to implement

Recovery education, lack of funding, the perceived lack of “buy in” by medical practitioners and the challenge of personal responsibility for recovery. In their view, without strategic leadership, funding and structures to support development, changes would not occur in practice.

In summary, the findings of this study support the belief that Recovery and WRAP education has the potential to increase psycho-social's knowledge, promote positive attitudes toward Recovery, and provide people with strategies to support mental health. It also has the potential to be a message of hope and empowerment. If delivered using the simple model used in this study, it has the ability to transform people’s world views, challenging traditional way in treating mental illness and power. One of the key elements contributing to the success of this program was the researcher’ knowledge of the area of Recovery and WRAP and their ability to create a non-judgmental, supporting and facilitative learning environment that enabled participants to actively engage with learning and transform their world views. This ran in tandem with their ability to create an environment where common humanity and vulnerability were respected and nurtured. Their knowledge and skills, together with their ability to practice and live out the values and beliefs upon which the program was conceived which supported with previous effort of the researcher in conducting study of effectiveness of WRAP on depressed patients in Gaza strip, ensured that the program was educationally relevant, emotionally supportive and ethically responsive.

Chapter six

Conclusion and Recommendation

6.1 Conclusion

This is the first study in Middle East which evaluated a Recovery and WRAP education program with representation from mental health care practitioners, drawn from multiple sites of community mental health directorate. The evaluation employed a multi-method approach using a pre and post test design with focus group interviews.

Findings from the study indicated that providing mental health practitioners with a systematic education and training in Recovery principles using the Wellness Recovery Action Planning approach leads to positive changes in people's knowledge, skills and attitudes towards recovery principles, and their ability to teach and facilitate these changes in others. This education also inspires, invigorates and empowers people, and for many, it is a life changing experience. While it can be concluded that the program was a success and achieved its objective of introducing the concepts of Recovery and Wellness Recovery Action Planning (WRAP) into the practices of mental health practitioners and teaching them strategies to promote mental health Recovery, it also moved beyond that objective. In addition to the research outcomes, as discussed, it is important to acknowledge that the project has provided a blue print for the development of Recovery and WRAP education in Palestine.

Finally, in addition to the recovery resource and educational materials developed by the researcher, the recovery education program has produced 47 WRAP facilitators, who are available to assist in moving the Recovery agenda forward. Mental Health Service Providers and Educators seeking to embed Recovery principles into service delivery and education are more likely to do so if they adopt the principles and methods used in the Recovery and WRAP education program used in this study.

6.2 Recommendations

In light of the findings from this study, the researchers make 5 recommendations:

1. A national mental health recovery plan and strategy for Palestine should be developed, with due consideration of the need to have a wider public focus and expand recovery education outside traditional mental health care environments into general health settings and the wider community, including schools and community networks.

2. The Community Mental Health directorate should be developing a national mental health recovery collaborative to put recovery at the heart of all mental health provision through Local Recovery Implementation Groups.

3. Inclusion of recovery principles, values and practices is central to undergraduate and postgraduate education curricula that prepare mental health practitioners to work in mental health services in Palestine.

6.3. Recommendation for further study

1. A follow-up study of participants be undertaken to examine whether the Changes reported in this study were maintained over time, and to examine how participants who completed the program used their knowledge and skills to support their own or others' mental health. It would also be important to explore what proportion of participants actually formulated a WRAP plan either for themselves or for someone else and facilitated a formal education program.
2. Study of the effectiveness of WRAP on the patient with different mental disorder should be considered.

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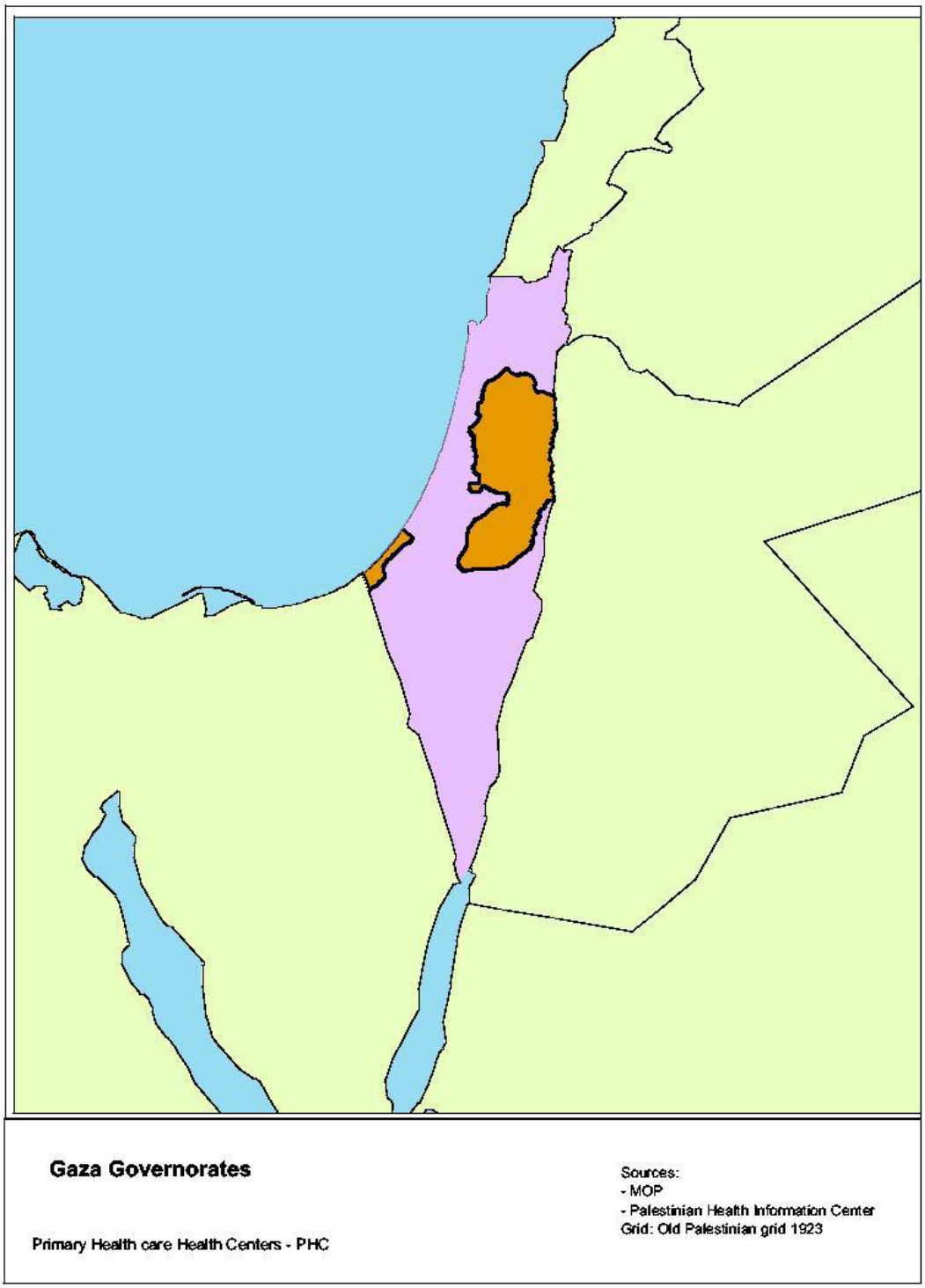
Annexes

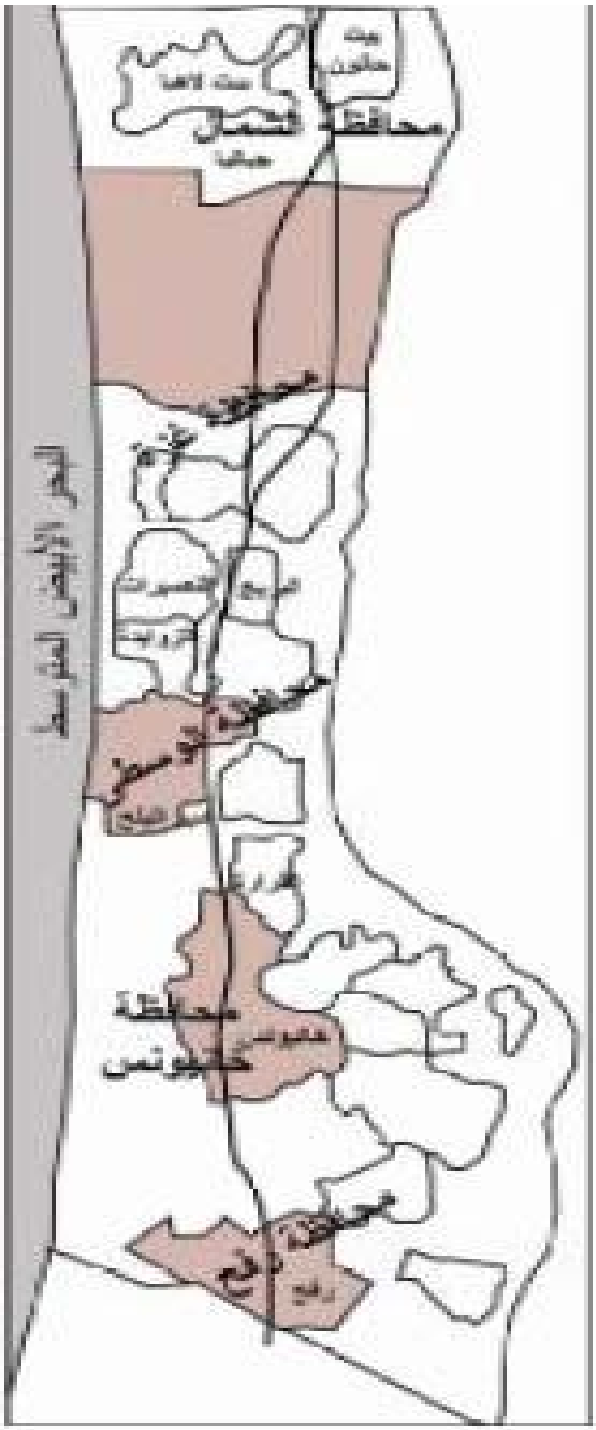
Annex (1).

Map of Palestine



Annex (2)

location of community mental health center



Source:

-MOGS

-Palestine Health Information Center

Annex (3): Arabic questionnaire

بسم الله الرحمن الرحيم

استبيان

اثر برنامج تدريبي مبني علي أداة الدمج والاستشفاء(WRAP)علي المعرفة والاتجاه لدي الأخصائيين النفسيين والاجتماعيين نحو عملية الدمج والاستشفاء

Effect of training program based on Wellness Recovery action Plan (WRAP) on knowledge and attitude of psychosocial workers toward recovery process.

الأخوة و الأخوات الزملاء الأعزاء:

هذه الدراسة يقوم بها الباحث كمتطلب للحصول على درجة الماجستير في الصحة النفسية المجتمعية –علوم التمريض الجامعة الإسلامية – كلية التمريض

يشكر الباحث لكم حسن المشاركة في هذه الدراسة من خلال الإجابة على أسئلة المقياس والتي لا تستغرق اكتر من 20 دقيقة من وقتكم الثمين وان مشاركتكم تسهم في إنجاح الدراسة التي تهدف للتعرف على مدي معرفتكم واتجاهاتكم نحو عملية الدمج والاستشفاء قبل وبعد تطبيق البرنامج التدريبي .

يود الباحث التأكيد على أن المعلومات ستبقى سرية و لهدف البحث العلمي لذلك لا داعي لذكر الأسماء

علما بأنه من حق الموظف الامتناع عن إجابة أي سؤال أو رفض المشاركة.

شكرا لكم على المشاركة

الإخوة الزملاء الأعزاء:

يشكر لكم الباحث موافقتكم على المشاركة ويود الباحث أن يوضح ما يلي :-

1. الأسئلة من 1-10 هي المعلومات والبيانات الشخصية يتم الإجابة بوضع علامة على المربع المناسب.
2. الأسئلة من 11-26 صممت لقياس المعرفة والإدراك لعملية الدمج والاستشفاء. يوجد مقابل كل سؤال خمس خيارات يتم وضع العلامة داخل المربع المناسب للموظف.
3. الأسئلة من 27-40 صممت للتعرف على اتجاهاتك نحو عملية الدمج والاستشفاء من المرض النفسي.

الباحث
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التاريخ: / / 2011 الرقم ----------

(خاص بالباحث)

البيانات الشخصية

من فضلك ضع إشارة × في المربع المناسب لك

1-العمر.....سنة

2-الجنس: ذكر أنثى

3-العنوان

☐ محافظة الشمال ☐ محافظة غزة ☐ محافظة الوسطى

☐ محافظة خان يونس ☐ محافظة رفح

4-الحالة الاجتماعية:

☐ أعزب/ آنسة ☐ متزوج/ ة

☐ أرمل/ ة ☐ مطلق/ ة

5-عدد أفراد الأسرة:.....

6- المستوى العلمي:

☐ دبلوم ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه

7- عدد سنوات الخبرة:.....

8-مكان العمل:

☐ مستشفى الطب النفسي ☐ دائرة التأهيل ☐ دائرة التدريب ☐ دائرة الخدمات

10-المهنة (حسب المسمى الوظيفي).....

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
	المعرفة					
11	اعتقد أن لدى المعرفة الكافية عن موضوع التعافي للمريض النفسي					
12	اعرف أهمية عملية التعافي كوسيلة يمكن أن تساعد المريض النفسي علي العودة لممارسة حياته.					
13	أستطيع التمييز بين حالات المريض النفسي المختلفة					
14	اعتقد بأهمية إعطاء الأمل بالنسبة للمريض النفسي					
15	اعرف كيف أساعد المريض النفسي علي التعرف علي نقاط القوي التي لديه.					
16	اعلم ما هي الوسائل التي يمكن أن تساعد المريض علي الدخول في عملية التعافي					
17	اعرف أسباب نجاح المريض النفسي في التغلب علي أوقات الأزمة					
18	اعرف أسباب فشل المريض النفسي في التغلب علي أوقات الأزمة					
19	اعلم جيدا خطوات التعافي الناجعة					
20	اعتقد أنني بحاجة إلى دورة تدريبية على عملية التعافي					
21	أحاول التعرف على كل جديد في مجال تأهيل المريض النفسي ودمجه في المجتمع.					
22	اعلم بأن المتابعة الجيدة للعلامات الأولية التي تنذر بالنكسة يمكن أن تساعد علي وقاية المريض النفسي من الانتكاسة					
23	اعتقد بأهمية تشجيع المريض النفسي علي المشاركة في التخطيط لعملية العلاج					
24	اعتقد بأهمية تشجيع المريض النفسي علي اتخاذ القرارات المتعلقة بحياته الشخصية					
25	اعرف بان التقليل من الوصمة المرتبطة بالمرض النفسي هي من أهم الوسائل التي تساعد في عملية التعافي عند المريض النفسي في المجتمع					
26	اعرف كيف أدون مراحل التدخل مع المريض بشكل تتابعي					

	الاتجاه					
27	التعافي (الاستشفاء) من المرض النفسي هو شي ممكن بغض النظر عن سبب هذا المرض					
28	الفهم الصحيح للمرض النفسي يساعد في التعافي منه					
29	لكي تتعافي أنت بحاجة للإيمان					
30	التعافي ممكن أن يحدث حتى مع وجود الأعراض					
31	الناس في مرحلة التعافي أحيانا يتعرضون لنكسات					
32	الناس يختلفون في طرق تعافيهم من المرض النفسي					
33	التعافي من المرض النفسي يمكن أن يتم حتى بدون مساعدة المهنيين في مجال الصحة النفسية					
34	كل الأشخاص الذين يعانون من أمراض نفسية شديدة يمكن أن ينجحوا في التعافي منها					
35	الأشخاص الذين يتعافون من المرض النفسي هم ليسوا مرضي نفسيين في المقام الأول					
36	عملية التعافي تحتاج للأمل					
37	الوصمة المرتبطة بالمرض النفسي يمكن أن تعيق عملية التعافي					
38	التعافي من تبعات المرض النفسي أحيانا يكون أصعب من التعافي من المرض نفسه					
39	العائلة يمكن أن تحتاج للتعافي من اثر إصابة احد أفرادها بالمرض النفسي.					
40	المريض النفسي سوف يحتاج لدخول المستشفي مرة أخري بالمستقبل					

الاسئلة لمجموعة النقاش:

1. **ماهو انطباعكم العام عن نموذج التعافي ومدي امكانية تطبيقه في الواقع العملي؟**

.....

.....

.....

2. **مـارايكم بالبرنـامج وهل محتـوي البرنـامج وطريقـة التقديم كانـت كافيـة لتوصيل المفهوم العام المتعلق بعملية التعافي ؟**

.....

.....

.....

تمت بحمد الله

Annex (4): English questionnaire

Effect of Training Program Based on WRAP on Knowledge and Attitude of Psychosocial Workers Toward Recovery Process.

Dear colleagues,

This study is carried out by the researcher, as a requirement for the Master Degree in community mental health nursing, at Islamic University, Faculty of Nursing.

In this regard, the researcher, thankfully, appreciates your effective participation in this study, through answering the questions of the questionnaire taking no more than 25 minutes of your valuable time. Actually, your participation contributes to the success of the study that aims examine effect of training program based on WRAP on knowledge and attitude of psychosocial workers toward recovery process.

Researcher would like to emphasize that the information will remain confidential and only for the purpose of scientific research.
Accordingly, there is no need to mention names, taking into account that a staff-member has the right to refrain from answering any question, or to refuse participation.

Thanks for your kind participation

Best Regards

The researcher
Mohamed Omran Abu Shawish .
Mobile: 0595588145

The researcher thankfully your effective participation and the researcher would like to clarify the following:

Questions 1-10 are personal information and answered by checking the appropriate box.

Questions 11-26 are designed to measure knowledge of recovery process. There are five options for every question select the appropriate box.

Questions 27-40 are designed to identify attitude of psychosocial worker regarding recovery process.

the questionnaire should delivered immediately after completion to the researcher or assistants.

Thank you

Date: ..../…./2010 **No.: ----------**

(for Researcher's use)

Personal Information:

Please, put × mark in the appropriate box.

1. Age: …….. years.

2. Sex: ☐ Male. ☐ Female.

3. residency:
   ☐ North Governorate ☐ Gaza Governorate ☐ Middle Governorate
   ☐ Khanyounis Governorate ☐ Rafah Governorate

4. Marital Status:
   ☐ Single ☐ Married
   ☐ Widower ☐ Divorced

5. Number of Family Members**: ……**
6. Monthly Salary (NIS): **…….**

7. Education:
   ☐ diploma ☐ Bachelor's Degree
   ☐ Master Degree ☐ PhD

8. Years of Experience: ……

9. Work Setting**:**
   ☐ Psychitric hospital ☐ Rehabiltation department ☐ Sraining department
   ☐ Service department

10. Job: as recorded in the MOH: ……

No.	item	Strongly agree	agree	hesitant	disagree	Strongly disagree
	Knowledge					
11	I believe I have sufficient knowledge on the subject of the psychological recovery of the psychiatric patient					
12	I know the importance of the recovery process as a means that can help the patient to return to control over his life					
13	I can distinguish between different cases of the psychiatric patient's					
14	I believe in the importance of giving hope for the psychiatric patient's					
15	I can help the psychiatric patient to recognize the strengths that he has					
16	I know what are the means that can help the patient to engage in the process of recovery					
17	I know the reasons for the success of the psychiatric patients in overcoming times of crisis					
18	I know the reasons for the failure of the psychiatric patient to overcome the crisis					
19	I know effective steps of recovery process					
20	I think I need a training course on the process of recovery					
21	I'm trying to identify all new in the field of rehabilitation of the psychiatric patient and Integrate him into the community					
22	I know that good follow-up of the early warning signs of relapse help to protect the patient from the psychological setback					
23	I believe the importance of encouraging mental patient to participate in the planning of the treatment process					
24	I believe the importance of encouraging mental patient to make decisions concerning his personal life					
25	I know that reducing the stigma associated with mental illness in the society is the most important tools that help the patient's in the recovery process					
26	I know how I record stages of intervention with the patient progressively					
	الاتجاه					
27	Recovery (wellness) from mental illness is something possible, regardless of the cause of the disease					
28	The correct understanding of mental illness help in recovery from it					
29	To recover you need the faith					
30	The recovery could happen even with the presence of symptoms					

31	**People in recovery is sometimes exposed to relapse**					
32	The people differ in the ways of their recovery from mental illness					
33	Recovery from mental illness can be done even without the help of professionals in the field of mental health					
34	All the people who suffer from severe mental illness can succeed in recovery					
35	People recovering from mental illness who are not mentally ill in the first place					
36	The recovery process need for hope					
37	Stigma associated with mental illness can hinder the recovery process					
38	The recovery from the consequences of mental illness sometimes be harder than the recovery from the disease itself					
39	Family may need to recover from the impact of mental disorder of one of its members					
40	Psychiatric patient will need hospitalization again in the future					

Focus Group questions

1. **What is your impression about the model of recovery and the possibility of its application in practice؟؟**

.....
.....
.....

2. **What do you think about the program and whether the program content and presentation was enough to connect the general concept on the recovery process ؟**

.....
.....

THANK YOU.

Annex (5): approval from CMHGD- Gaza governorate

Palestinian National Authority
Ministry of Health
Mental Health General Administration

السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة للصحة النفسية

Date: 12/07/2012

الرقم:

السادة / المدراء الطبيين للمراكز حفظهم الله،،،

السادة / المدراء الإداريين للمراكز حفظهم الله،،،

السلام عليكم ورحمة الله وبركاته،،

الموضوع / تسهيل مهمة باحث

بخصوص الموضوع أعلاه يرجي تسهيل مهمة الباحث الحكيم/ **محمد عمران أبو شاويش** رقم وظيفي **49318** الملتحق ببرنامج ماجستير الصحة النفسية بالجامعة الإسلامية و عنوان البحث:

" فعالية برنامج تدريبي لتغير معرفة واتجاهات الأخصائيين النفسيين والاجتماعيين نحو عملية الدمج والاستشفاء"

حيث سيقوم الباحث بالاستعانة بالطواقم الفنية في عيادات الصحة النفسية المجتمعية، كما سيقوم بتعبئة الاستبيانات لعينة من العاملين وذلك حيث لا يكون يتعارض مع مصلحة العمل في المراكز ويكون ضمن أخلاقيات البحث العلمي دون تحمل المراكز أي أعباء من إجراء هذا البحث.

وتفضلوا بقبول فائق الاحترام والتقدير،،،

د. عايش سمور

مدير عام الصحة النفسية

الدكتور عايش سمور
مدير عام الصحة النفسية
مدير مستشفى الطب النفسي الإفرنجي لامراض النفسية

فلسطين – غزة – شارع العيون – مستشفي الطب النفسي تلفاكس: 08.2879845

Email : g.d.o.mental_health_gaza@hotmail.com

Annex (6): list of control names (alphabetically)

Dr. Abed Al-Kareem Radwan

Dr. Abed Ahamid Afana

Dr. Ayish Samour

Dr. Khadra Al-Amassy

Dr. Mustafa Al-Massary

Dr. Omer Al-Buhissy

Dr. Samir Quota

Dr. Yousef Awadallah

Mr. Diaa Sayma

Annex (7):

Correlation between each statement of the field and the total of this field

No.	Correlation value	No.	Correlation value
11	0.635 * *	19	0.744 **
12	0.526 **	20	0.363 **
13	0.608 **	21	0.213 //
14	0.650 **	22	0.399 **
15	0.555 **	23	0.360 **
16	0.662 **	24	0.429 **
17	0.390 **	25	0.475 **
18	0.482 **	26	0.528 **

No.	Correlation value	No.	Correlation value
27	0.434 **	34	0.682 **
28	0.771 **	35	0.692 **
29	0.620 **	36	0.438 **
30	0.692 **	37	0.678 **
31	0.369 *	38	0.688 **
32	0.574 **	39	0.570 **
33	0.640 **	40	0.734 **

Annex (8): Split half

Dimension	No. of items	Correlation	Spearman-Brown equation	P value
Knowledge	16	0.795	0.886	0.000
Attitudes	14	0.709	0.830	0.000

Annex (9): WRAP

WRAP Wellness Recovery Action Plan

Design by:-

Mohamed. Omran Abu Shawish

Mohannad Omar Hamdan

Islamic University Gaza

2010

FORWARD

Wellness Recovery Action Plan (WRAP) was originally developed by Mary Ellen is an author, educator and mental health recovery advocate she developed this self-management plan with other like-minded people who wanted to have more control over their illnesses. WRAP is widely used in America and is now becoming widely recognized in the U.K. In Islamic university we have developed this form for students of community mental health nursing master program. filled by student him self for practice purpose, and we include in these form the Ten Essential Sheared Capabilities to be comprehensive guide for students in practical sittings.

خطة عمل الاستشفاء واسترداد العافية وضعت أصلا من قبل ماري الين كوبلن هي صاحبة الخطة ،هي مثقفة في مجال الدمج والاستشفاء للصحة النفسية وضعت هذه الخطة مع آخرين يمتلكون نفس طريقة التفكير و الذين يريدون الحصول على مزيد من السيطرة على حياتهم أصبحت تستخدم على نطاق واسع في أميركا ، والآن أصبح معترف بها على نطاق واسع في المملكة المتحدة

Mohamed Abu Shawish
Mohannad Hamdan

WRAP INCLUDE

Wellness العافية

The wellness section is a description of what an individual is like when they are well.

هو عبارة عن وصف شخصي للشخص حينما يكون بصحة جيدة

Wellness Toolbox كتاب أدوات العافية

The wellness toolbox is a general list of things that an individual knows keeps them well and those things that they need to avoid, as they know they made them feel less well.

عبارة عن أشياء وممارسات يرى الشخص أنها تساعده فيحافظ عليها وأخري تثبط يريد أن يتجنبها

Daily Maintenance الممارسات اليومية

The Daily maintenance section is a list of things that an individual needs to do daily, weekly or monthly to stay well.

نشاطات و أعمال يحتاج الشخص القيام بها إما يوميا أو أسبوعيا أو شهريا

Triggers إشارات

Triggers are external events or circumstances that may make a person feel less well. An individual writes their personal triggers then an action plan of what to do if they were to occur.

هي عبارة عن إشارات أو ظروف خارجية أو محيطة تشعر الشخص بأنه اقل صحة، الشخص يكتبها ويكتب خطة التعامل معها إن ظهرت

Early Warning Signs علامات الأزمة المبكرة

Early warning signs are the subtle internal signs of change that indicate to an individual that they are becoming less well. These personal signs of change are listed with an action plan of what to do if they occur.

هي عبارة عن علامات وإشارات داخلية تشير إلي أن الشخص مقبل علي أزمة وخطة التعامل معها في حال الحدوث

When Things Are Breaking Down عند الوقوع في الأزمة

When things are breaking down, these are feelings and behaviors that indicate to an individual that things are more serious and that they need to take immediate action to prevent things from worsening. An individual writes a list of signs that things are breaking down for them and an action plan of what to do if they were to occur.

المشاعر والسلوكيات التي تشير إلي أن الشخص في أزمة صعبة وهو بحاجة للتصرف بسرعة لمنع تدهور الأمور مع وضع خطة لكيفية التعامل مع الأمور في حال وقوع الأزمة

Crisis Plan خطة الأزمة

A crisis plan is a comprehensive plan that is written when the person is well. It tells others how they would like to be cared for when they can no longer care for themselves. There are several sections to this plan and individuals are encouraged to adapt it to their needs in a time of crisis.

هي عبارة عن خطة شاملة يضعها الشخص في فترة ما قبل الأزمة موضحا فيها كيف يريد من الآخرين أن يساعدوه ويدعم الشخص لتكييف الخطة بما يتناسب مع احتياجاته في وقت الأزمات

Post Crisis Plan خطة مابعد الأزمة

A post crisis plan is a plan of how others will know when they no longer need to take over the care of an individual. It also includes a reducing support plan as an individual starts to take back responsibilities and recover from the crisis.

عبارة عن خطة توضح للآخرين أنني لم اعد بحاجة للمساعدة واستطيع أن اعتني بنفسي وتحتوي علي خطة تخفيض مستوى المساعدة بالتزامن مع استعادة المسئوليات.

Wellness Recovery Action Plan (WRAP) form

استعادة العافية- نموذج خطة العمل

Client name: ----------اسم المريض

1- Daily maintenance list 1- قائمة الأعمال اليومية

Words may help you in developing your list كلمات يمكن أن تساعد

Friendship (الصداقة) – happy (السعادة) – optimistic (التفاؤل) – quiet (الهدوء)– responsible) (المسئولية – reasonable (الواقعية) – energetic (النشاط) – active (فعال) – humorous (الدعابة) – religiously believed (معتقدات دينية) – belonging (انتماء) – love (الحب)– calm (هادئ)– empathic (متعاطف)– cooperation (متعاون).

When I'm all right I like عندما أكون بخير أنا أكون علي هذا الشكل

Daily activities and practices that keep me feel well

الأنشطة اليومية والممارسات التي تمكنني من المحافظة علي الشعور بشكل أفضل.

(sleep patterns(نمط النوم)- praying(الصلاة)- religious rituals(طقوس دينية) – eating(الأكل)- relaxation(الاسترخاء) – medication(العلاج) – social activity (نشاطات اجتماعية)– working (العمل)- fun (المرح) – having special time(الحصول علي وقت خاص)- exercise (الرياضة):

---

2 – Triggers 2- عوامل القدح

(External events or circumstances may make you feel like you are getting ill. الأحداث الخارجية أو الظروف التي تجعلك تشعر وكأنك تصاب بالمرض

Things if they happened may increase my tendency for deterioration: – أشياء إذا حدثت قد تزيد الأمور سوءا

Triggers المحفزات	Response الاستجابة

Things that I can do if my triggers come up to overcome this trigger: الأشياء التي يمكنني القيام بها إذا دقت هذه المحفزات الباب للتغلب عليها

3- Early Warning Signs and action plan: 3- علامات الإنذار المبكر وخطة العمل

Are internal and may be unrelated to reactions to stressful situations indicate that you may need to take some further action.

هي إشارات داخلية ويمكن أن لا يكون لها علاقة بردود الفعل على المواقف العصيبة و تشير إلى أنك قد تحتاج إلى اتخاذ بعض الإجراءات الأخرى.

Early Warning Signs علامات الإنذار المبكر	action plan خطة العمل

4- Breaking down signs: 4- علامات دخول الأزمة الأولية

Breaking down signs العلامات	action plan خطة العمل

Very uncomfortable feeling like the situation is serious and even dangerous but you are still able to take some action in your own behalf. شعور غير مريح للغاية يماثل الوضع الصعب وقت الأزمة ولكن كنت لا تزال قادر/ة على اتخاذ بعض الإجراءات في مصلحتك الخاصة

5- Crisis planning:- 5- التخطيط للأزمة

This plan written when I'm well aimed to instruct others about how to care for me when I'm not well and help me to keep control.

هذه الخطة اكتبها عندما أكون بخير تهدف إلى إرشاد الآخرين عن كيفية مساعدتي عندما لا أكون كذلك وتساعدني على الاحتفاظ بالسيطرة

What I'm like when I feel well (you my refer to the part one of **(WRAP):** عندما أكون بخير أنا أكون: (يمكنك الاستعانة بالجزء الأول من الخطة)

Supporters (الداعمين) (persons you wont to take over for you, family member, friends, care provider**):** أشخاص أنت تريد أن يساعدوك من عائلتك آو أصدقائك أو المعالجين)

Name الاسم	Dedicated Role الدور	Telephone Number رقم التلفون
1-		
2-		
3-		
4-		

Medications: الأدوية:

Name العلاج	Dose الجرعة	Frequency الأوقات
1-		
2-		
3-		
4-		
5-		

Treatment (العلاج):(list treatment modalities you would like and those you wont to avoid including alternative):

أساليب وتقنيات العلاج التي تفضل أن تتلقاها و الأخرى التي لا تريدها مع اقتراح بدائل

Treatment and alternative therapies you would like الأساليب التي تفضلها	Treatment and alternative therapies you wouldn't like الأساليب التي لا تفضلها

Community resources (المصادر المجتمعية): (list what resources may help you are available in your community like (home, community care)):

قائمة الموارد المتوفرة في مجتمعك التي قد تساعدك مثل (المنزل ، الرعاية المجتمعية، الخ)

Help from others: المساعدة من الآخرين

List things others do for you that would help أشياء تريد أن يفعلها لك الآخرين لمساعدتك	List things others do for you that wouldn't help or make you worse أشياء لا تريد أن يفعلها لك الآخرين لأنها تضايقك وتزيد الأمر سوءا

Signs indicates that I returned control over my wellness:
العلامات التي تشير إلي أنني استعدت عافيتي وسيطرتي علي الأمور

I'm recovered from this crisis, I would like to feel:

لقد استعدت عافيتي بعد الازممة انا احب ان اشعر بانني:

You may want to refer to (WRAP)- "what I'm like when I'm well"
This may be different from what you feel like when you are well- your perspective may have changed in this crisis)

يمكن تن يتشابه هذا مع الجزء الاول من الخطة ولكن الاختلاف هنا ان نظرتك للامور يمكن ان تختلف بعد الازمة

Signs that this post crisis phase is over and can return to using my daily maintenance plan that might help prevent a crisis in the future:

علامات تشير الي ان مرحلة مابعد الازمة قد انتهت واستطيع ان اعود لممارسة نشاطاتي اليومية التي يمكن ان تمنع تكرار الازمة

Post recovery supporter list

اشخاص احب ان يساعدونني في مرحلة مابعد الازمة

I would like the following people to support me if possible during this crisis time:

Name: الاسم	Telephone التلفون	What I need them to do ماذا اريد ان يفعلوا لي

6- Post Crisis Plan

6- خطة ما بعد الأزمة

What did I learn from this crisis? **ماذا تعلمت من الأزمة**

Changes I want or need to make in my life as a result of what I have learned and when and how will I make these changes?

أشياء في حياتي أريد أن أغيرها في ضوء ما تعلمت من الأزمة و متى وكيف سأقوم بهذه التغيرات

Changes التغيرات	when and how will I make these changes متى وكيف سأقوم بذلك

Timetable for Resuming Responsibilities **جدولة استعادة المسئوليات**

Responsibility: **المسئوليات**	**Who has been doing this during crisis** **من الذي كان يقوم بها أثناء الأزمة**	**Plan for resuming this responsibility** **خطة استعادتها**

Signature _____ **Date** _____