
Teaching Family Carers About the Recovery Concept in Mental Health: An Exploration of the Potential Impact of Utilizing an Online Program

Joanna Fox¹
Anne-Marie Smith²
Paul Driver¹
Debora Vasconcelos e Sa¹

¹Anglia Ruskin University, Cambridge, UK

²University of Hertfordshire, UK



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KEYWORDS

Online program, Recovery, Caregivers, Carers, Recovery for families

Abstract

Objective: This research explores whether the delivery of an online training program on recovery to a group of family carers can be beneficial and add to the evidence base about the importance for family carers to understand the recovery approach. The emergence of COVID-19 required the program and evaluation to be completed online, using both synchronous and asynchronous learning.

Research design and methods: The framework was dissemination and implementation science, which focuses on developing real-world research implementation and facilitates the timely adoption of effective interventions into health and care systems. The research methodology was participatory action research. An advisory group of stakeholders representing carers, service users, and professionals directed the study design and implementation. Mainly qualitative data was collected, together with supplementary socio-demographic quantitative data. Seven carers started the program, with five remaining to completion and participating in the evaluation.

Results: The findings emphasize the importance of understanding recovery, supporting recovery, and considering carers' own needs alongside their recovery. The carers evaluated the training as successful, highlighting the importance of the user- and carer-trainer in delivering the program.

Conclusion: COVID-19 impacted the participant recruitment and the delivery of the intervention. The small sample size limited the validity of the evaluation and the findings

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Corresponding author: Joanna Fox. Email: Joanna.fox@aru.ac.uk

reported. Additionally, not all participants engaged with all sessions. This makes it difficult to report the fidelity of the intervention. However, the results endorse the implementation of a comprehensive study to explore further the potential benefits from participation in this intervention for this population of carers.

Introduction

Family carers often provide unpaid support to their relatives with mental ill-health in diverse ways;¹ however, there is a lack of training and support to enable them to care effectively.² The provision of training programs for carers is a requirement of current guidance,³ and recently, training opportunities have become increasingly available for carers of people with specific mental health conditions, such as personality disorder^{4, 5} or schizophrenia.⁶ This research explores whether the delivery of an online training program on recovery, developed in earlier research,^{7, 8} to a group of six mental health carers can be beneficial and add to the evidence base concerning the importance for carers to understand the recovery approach.⁷⁻⁹ A unique addition to the development and delivery of this course⁷⁻⁹ are the first author's experiences of recovery as a service user for over thirty years, with a diagnosis of mental ill-health,^{10, 11} which intersects with her passion to make change in mental health care.

In accordance with dissemination and implementation (D&I) science,¹² which focuses on developing real world research implementation¹³ and facilitates the timely adoption of effective interventions into health and care systems, the course, developed in this research, and the evaluation methods proposed were piloted for future development and roll-out. The COVID-19 pandemic required the original blended learning training program to be taught online via synchronous and asynchronous learning, allowing a pilot of a fully online intervention and evaluation. To illustrate the potential utility of this intervention alongside the evaluation processes, the initial experiences of the carer participants are shared to underline the potential to improve carer-givers' understanding of recovery and to explore the course value. This accordingly will feed into the development of further studies, which will allow us to confirm the utility of this pilot.

The recovery approach is an aspirational model in mental health care and highlights that people with mental ill-health conditions can lead positive lives, despite the emergence of distress and associated symptoms.^{10, 11} The CHIME model of recovery¹⁴ conveys that recovery is perceived as a unique journey that requires Connectedness, Hope and optimism about the future, the creation of Identity, Meaning in life, and the need for Empowerment. The nature of recovery is often understood as an ambiguous state¹⁵ and can sometimes be associated with successful medical outcomes rather than social recovery.¹⁶ The recovery concept is often unknown to the wider population of carers,^{7, 8} although its impact on the development and provision of services is significant.¹⁷ Thus, its importance underlines both its relevance to carers and potential to play a useful role in supporting carers to care more effectively.^{7, 8}

Mental health carers provide unpaid care by undertaking vital tasks, such as providing psychological, emotional, and practical support in day-to-day tasks and times when mental ill-health symptoms make daily life more challenging.¹ Caring impacts many

individuals in society;¹⁸ this was indicated by the 2011 census, the most recent population survey in the UK, which found that 6.5 million people in the UK were carers. There were further projections of the number being approximately 8.8 million carers in 2019.¹⁸ Furthermore, caring can impact dramatically on carers' physical and mental health,¹⁸ while young carers and female carers supporting people with mental ill-health experience the poorest well-being.¹⁹

Carers often experience both limited support²⁰ and lack of information about current policy, practice, and mental health philosophy.²¹ Thus, understanding the recovery approach can be liberating for carers, enabling them to develop a more hopeful and optimistic approach,^{22, 23} but its significance to their caring role is seldom recognized.⁸ However, the provision of supportive interventions^{2, 6} can improve carers' experiences of caring and their quality of life. Reflecting a growing evidence base,⁴⁻⁶ the latest guidance for supporting carers in England, developed by the National Institute for Health and Care Excellence,^{3, 24, 25} stipulates that mental health services should offer carer training programs that improve carers' knowledge and coping skills and are delivered in a variety of accessible formats.

Although there are diverse forms of carer intervention,²⁴ training programs should focus on conveying a sense of hope and optimism as these elements are associated with better adjustment.²⁵ This echoes the emphasis in recovery on reinforcing positive messages,¹⁵ central to this program. Research undertaken by the first author⁷⁻⁹ leads us to conclude that there is a dearth of research and pragmatic implementation of evidence-informed practice to support carers locally and nationally; moreover, there are very few interventions that enable carers to learn about the positive impact of recovery and how it can influence their caring role.⁸ This current study thus builds on initial exploratory work about the importance of enabling carers to learn about recovery^{8, 9} and develops it further through the delivery of knowledge via an innovative online course.⁷

The utilization of online packages of education for carers is relatively recent.^{7, 26} Drawing on Garrison & Kanuka,²⁷ blended learning is described as "the integration of traditional classroom methods with online activities (termed 'e-learning')." ²⁸ Blended learning amalgamates face-to-face learning, which builds peer support, with e-learning, which reduces learners' travel and time commitments in attending a program.²⁸ The intersection of online learning with face-to-face interaction enables participants to integrate knowledge gained through online engagement with the opportunity to collaborate with peers to co-construct their learning experiences.²⁹ The emergence of the COVID-19 pandemic required all learning to be moved online, and the format incorporated both synchronous and asynchronous learning. Despite the advantages of online learning in academic situations, many learners with non-traditional backgrounds may not have the experience, knowledge, or confidence to access e-learning opportunities, thus remaining disadvantaged; moreover, they may lack access to appropriate and effective technology. Despite these caveats, academics and trainers developing health and social care education increasingly employ blended learning formats for the delivery of training.^{28, 30-33} This development suggests the potential for the implementation of such methods in carer training programs, although, as highlighted above, the COVID-19 pandemic forced all learning in this iteration of the course to be delivered online.

The study thus bridges the gap in the evidence identified above. It explores the potential usefulness of learning about recovery for carers through a pilot delivery of an online program to six participants and potential evaluation methods. In this study, the following research questions are posed:

- Does this intervention have the potential to enable carers to learn about recovery?
- Do the initial results of this pilot program indicate that learning about recovery is beneficial to carers?
- Does this pilot program indicate that online learning is an effective way to support carers to learn about recovery?
- Does this process of evaluation have potential to explore the effectiveness of this course?

Research Design and Methods

D&I science,¹² which focuses on developing real world research implementation,¹³ underpins this project; such frameworks facilitate the timely adoption of effective interventions into health and care systems. The methodology used in this study is participatory action research (PAR), which focuses on involving user and carer collaborators at all levels of decision-making in the research.³⁴ PAR framed the research process. The ability to implement change through the action research cycle was particularly useful given the COVID-19 pandemic, which affected the implementation of the program; adjustments are described below. This adaptation is equally appropriate to the format of D&I science,¹² which supports the swift implementation of effective interventions into health and care systems.

An advisory group of professionals, carers, and users steered the project through the action research cycle, including two carers, although Carr et al. comment that carers rarely participate in co-produced research.^{35, 36} Some members involved in preliminary research were also invited to participate.^{7, 8} Diverse stakeholder expertise, including carers, service users, professionals, and academics contributed to the development of the training program through a process of co-production, as previously described in Fox.⁷ The content of the sessions is described in Table 1.

Table 1.

Training program sessions and pre- and post-intervention

Session	Content	Format
Pre-intervention contact	Information sheet/consent form Socio-demographic questionnaire: closed questions Response to case study: open questions SCORE-15 questionnaire: closed questions	Completed online
1	Introduction to recovery	Optional Zoom face-to-face
2	Carers' assessment and recovery	Completed online
3	A carer's own journey of recovery	Optional Zoom face-to-face
4	Mental health services and recovery	Completed online
5	The carer's and service user's journey	Optional Zoom face-to-face
Post-intervention	Response to case study: open questions SCORE-15 questionnaire: closed questions Evaluation of training program: open questions	Completed online

Ethical Approval

University Faculty Ethics Committee Approval was gained (Application reference ESC-SREP-10-021). The research participants were sent the information sheet and consent form online, which they were asked to complete before joining the research. It had been intended to hold an initial face-to-face meeting to both discuss the research and answer questions, but face-to-face contact was prohibited due to the emergence of the Covid-19 pandemic. Moreover, all training was moved to an online format, and synchronous virtual meetings replaced the face-to-face sessions. Additionally, the course was evaluated via online questionnaires, rather than using focus groups and questionnaires. The university ethics committee was informed of the changes to the evaluation and course format and these adaptations were given approval.

Delivery of Course

An online training intervention on recovery was delivered to a group of six mental health carers recruited via snowball and convenience sampling through practitioner networks.³⁷ The program, as originally conceived, comprised three face-to-face sessions and two online sessions, but the onset of the pandemic forced us to move all sessions online. Thus, the face-to-face sessions were replaced by optional synchronous online sessions. All forms of virtual connection were GDPR (general data protection regulations) compliant.

There were many reflective activities (using embedded forms), images, case studies and flip-card interactivity. Narrated slides were recorded and uploaded to the training website. With the support of a learning technologist (third author), the carer trainer recorded her story about caring for her son who experiences psychosis. The optional synchronous virtual sessions were co-delivered by the first author using her own experiences of recovery, and the carer-trainer to ensure coherence with co-production models;

additionally, a psychiatrist joined part of a synchronous session to reinforce the importance of using the recovery approach in professional care and support. The participants spent an average time of 78 hours and 48 minutes on the course (4,709 minutes total for all 5 that remained). The training program content is described in Table 1; however, it is not discussed further in this paper due to the limited space, although its development is reported in Fox.⁷

Firstly, data from a socio-demographic questionnaire was circulated to all participants and collected and analyzed through Statistical Package for Social Sciences (SPSS). Secondly, open questionnaires based on a vignette enabled an understanding of participants' changing response to the recovery concept by capturing qualitative data about the impact of participation in the program. The vignette comprises the case of a young person, John, who was employed previously as an electrician but has not worked since he developed mental ill-health. John has hobbies and interests that he is developing but is thinking of stopping medication due to the side effects, which concerns both his parents and professionals. The open questions accompanying the vignette served to enable respondents to both explore their own reality and to consider how they thought the characters in the vignette ought to act "from a non-personal and therefore less threatening perspective"; this is a strength of vignette techniques.³⁸ Finally, open questions allowed us to explore the usefulness of an online approach in facilitating access to completing training. All questionnaires were presented online using Qualtrics®, an online survey platform.

The limited qualitative feedback was analyzed using thematic data analysis.³⁹ A process of iterative movement between the literature and the data from the research allowed us to contextualize the data from this pilot in the wider context, which confirmed its potential utility for further roll-out. The first author's personal position in developing, delivering, and evaluating the program had the potential to lead to research bias.⁷ However, a process of reflexivity was utilized to consider any bias, alongside the inter-rater reliability input from another rater from the advisory group, the fourth author, who analyzed the research themes.

After some discussion in the steering group, we piloted the use of SCORE-15 to collect quantitative data about the potential utility of attending the training program. SCORE-15 is a self-report measure, which has 15 Likert scale items assessing family functioning and therapeutic change following involvement in an intervention.⁴⁰ This measure was employed to explore if it could capture whether participation in the training program was beneficial for carers.

Action Research Cycles

The learning technologist constructed the framework of the course on a GDPR-compliant platform that was accessible and visually attractive. This was circulated to all advisory group members for comments; members also trialled some of the activities on the new platform. The course was scheduled to start in April 2020. However, the COVID-19 pandemic prevented face-to-face teaching, and the course was postponed. As lockdown continued, we canvassed the participants' opinions on undertaking the course online. This option was initially rejected; but when participants were consulted at a later period, they

opted to participate in the program. Reasons for this initial decision included the importance of face-to-face peer support, the difficulty to schedule private time when the service user was in the house, and the lack of privacy—and for some participants, the service user could potentially become aggressive if their carer was known to be participating in a course. We met with the advisory group who fully agreed with this approach; moreover, course delivery had to be completed by the end of the funding period, which was mid-July 2020.

Sample

Flyers were sent through the extensive dissemination lists owned by a local private voluntary independent carers' provider organization, and a local carers support group in January 2020. Inclusion criteria were clearly indicated: the course was open to people who self-identified as unpaid carers of people who experienced serious mental ill-health. However, the cared-for person was not required to have a formal diagnosis or to use services. We had permission to send the flyer out to ward managers in the local mental health trust to display in clinics; flyers were subsequently displayed in the early intervention service clinics.

Eight candidates responded to the flyers. Seven were interviewed by telephone and were recruited to participate; the final candidate withdrew on finding out that the course had an online delivery. Seven carers began the course. One withdrew from the research after attending session 2 due to personal difficulties related with the caring situation. Another participant filled in the pre-intervention questionnaires and attended session 2, but did not respond to any further contact. The socio-demographics of the research participants are depicted in Table 2 and the details of their engagement in Table 3.

Table 2

Descriptive information for the carer and service user sample (n= 6)

	Carers		Service Users	
	Mean (<i>SD</i>)	Range	Mean (<i>SD</i>)	Range
Age	48 (8.9)	32-57	30 (9.7)	21-43
	Frequency		Frequency	
Gender				
Female/Male	3/3			
Marital status				
Married			2	
Single			4	
Ethnicity				
Asian/Asian British	1		1	
White/White British	5		4	
Other			1	
Highest level of education				
Secondary	1			
Tertiary/Further	6			
Occupational status				
Employed (full-time)	4			
Employed (part-time)	1			
Unemployed	1			
Living arrangements				
Alone	2			
With parents				
With husband/wife	1			
With other relatives	1			
With others	1			
Other	1			
Caring for				
Son	2			
Daughter	1			

Wife	2
Partner	1
Caring hours per week	
<15 hours per week	2
15-25 hours per week	2
>15 hours per week	2
Caring duties	
Help in/around house	5
Help outside house	1
Carer's assessment	
Yes	3
No	3
Mental health issue onset	
1-3 years ago	2
3-5 years ago	1
> 5 years ago	3

Table 3

Attendance at sessions

Carers	Pre-intervention questionnaires	Session 1	Session 2	Session 3	Post-intervention questionnaires
PARTICIPANT 1	X		X		X
PARTICIPANT 2	X	X	X	X	X
PARTICIPANT 3	X	X		X	X
PARTICIPANT 4	X		X	X	X
PARTICIPANT 5	X	X		X	X
PARTICIPANT 6	X		X		
PARTICIPANT 7	X	X		Withdrawn from research	

Although this is a small sample, it begins to show the potential of the program in meeting the needs of family caregivers. Moreover, the action research methodology and its review cycle,³⁵ alongside the implementation of D&I research,¹² highlight the potential of this intervention for future roll-out and enable learning from this study to be incorporated into future programs.

Results

The results from this pilot study indicate the potential effectiveness of the methods. The findings from the SCORE-15 questionnaires are inconclusive due to the small number of participants attending the course and thus are not discussed in more detail in this article due to restricted space. Moreover, SCORE-15 will need further piloting to assess its utility for use in further studies to evaluate change in family function following the training intervention on recovery.

Furthermore, although the sample is small, and the data collected limited, the qualitative findings enable us to explore the potential impact of recovery on carers and enhances the need to further develop this program. The qualitative findings are presented to enable discussion of the potential utilization of this intervention and the methods to evaluate it. The main themes are divided into three sub-themes that were inductively generated. The findings emphasize the importance of understanding recovery, supporting the service user's recovery, and the participants' requirements to consider their own needs as carers in their own recovery journey. These highlight the importance of this topic to carers and the potential for them to learn about this process.

Understanding Recovery

Recovery was understood by the participants in diverse ways. At the pre-intervention point, participant 3 understood recovery as a return to pre-morbid functioning and wanted to see John (the hypothetical person in the vignette) returning to life as it was before the illness developed.

PARTICIPANT 3 (Pre-I¹): "With the right support and treatment, I would hope John would be able to find employment and have re-connected with friends."

However, participant 4 was in the early stages of caring for her son; at the post-intervention stage, she recognized recovery as a journey.

PARTICIPANT 4 (Post-I²): "A long journey and a very difficult illness to manage, as a carer and a parent you see the changes mental health has on life, career, university, mental health changes, relationships, and family."

Moreover, participant 5 clearly noted that there are different stages to the recovery journey and different moments of recovery, as reflected in many models.⁴¹ This participant also underlined the need to promote hope and optimism in the care of the service user. At the post-intervention stage, participant 5 recorded:

¹ Pre-I refers to the responses given by participants pre-intervention, and Post-I refers to responses collected after the intervention.

PARTICIPANT 5 (Post-I): “We can be at different stages in recovery process, so we can recognise that we will not be stuck—to be brave and ask for help for all. Recovery sees the person as a whole and recognises humans as social beings who all need to express themselves and find a purpose to enjoy their lives.”

This was echoed at the post-intervention stage by participant 3, who noted that the importance of recovery was that:

PARTICIPANT 3 (Post-I): “[It] [H]elps those with mental health issues/carers feel a sense of achievement; gives them control over their situation and gives them something to focus on and work towards (Rome wasn’t built in a day and once it was but it still needs ongoing support and maintenance to stay standing) .”

It was also acknowledged at the post-intervention stage that it was important for the cared-for person to set their own recovery objectives and to define what this concept meant for the service user themselves.

PARTICIPANT 2 (Post-I): “Made me think more of what the person recovering wants to achieve, how to be supportive, focus on the positives.”

Thus, carers understood recovery variously as a return to pre-morbid functioning and a journey and acknowledged the importance of hope and optimism in this journey.

Supporting the Recovery Journey

The second theme relates to understanding the elements that support the recovery journey. At the start of the course, some participants had a sophisticated sense of their enabling role as a carer, as described below:

PARTICIPANT 2 (Pre-I): “I try to be a supportive companion, going to clinic and doctor’s appointments as much as I can, going out together for walks, coffee, shopping. I try to make each interaction positive with humour and praise, but not pushy.”

Although one carer saw their role as encouraging and guiding their relative to stay on track, themes of guilt were expressed by another participant as they reflected on their role. Participant 1 reported this at the post-intervention stage when considering the experiences of the family in the vignette as they supported their hypothetical son:

PARTICIPANT 1 (Post-I): “Because parents will feel emotionally is it something I have done or what more could I have done to support my child there is always the inner fears.”

At the pre-intervention point, this small sample of carers concurred that engagement with services and clinical intervention from professionals are central to the effective recovery of their relative. Participant 1 noted in response to questions related to the vignette that he would give the following advice to John’s parents:

PARTICIPANT 1 (Pre-I): “Engage with treatment services, focus on his recovery, and then slowly introduce things one at a time once he has got his life stabilised.”

Moreover, the theme of medication as key to recovery was very prominent, alongside acknowledgement of the importance of building close relationships with services.

PARTICIPANT 3 (Post-I): "Maintaining his medication is key as that will help control some of the symptoms."

The participants noted the importance of both carers' and professionals' support in the recovery journey. They highlighted the role of medication in maintaining well-being, connecting this with their conceptualization of recovery.

Carer's Needs and Their Own Journey of Recovery

This section considers how carers need to take care of their own well-being and are travelling on their own journey of recovery, in addition to the recovery the service user is experiencing. Even at the pre-intervention point, participant 6 reported the importance of the parents being kind to themselves as carers in the hypothetical vignette:

PARTICIPANT 6 (Pre-I): "My advice would be to visit once a week and try slowly to understand what's happening to their son and not blame themselves."

This is in antithesis to the self-blame and guilt that this small group of carers expressed at different points in the program. However, even before participation in the training, participant 5 recognized how caring sapped her energy and how she herself had her own needs when thinking about the meaning of recovery.

PARTICIPANT 5 (Pre-I): "To be able to build some inner strength to understand how to take care of my needs and thus enable me to maintain and build on the relationship to the person I care for. . . . Sometimes it feels like we forget ourselves and give up our lives when we care for others."

Participant 3 expressed the need to acknowledge the recovery of the carer in the vignette offered in the evaluation:

PARTICIPANT 3 (Post-I): "Their own recovery is just as important as John's. They need to set their own realistic and achievable goals."

Participant 5 was of British Asian ethnicity. She experienced discrimination from her community of origin because of her caring situation. She encountered associative stigma,⁴² which is a process in which a person is stigmatized by virtue of their association with another stigmatized individual.

PARTICIPANT 5 (Post-I): "Stigma and lack of awareness from family and community. . . . The carer may also have related MH conditions such as depression and anxiety and cultural expectations of responsibilities which are a hindrance to them seeking support for their needs and also to know how to let go of the caring responsibility and enjoy just the relationship and their lives without grief, guilt, and lack of trust."

Participant 5's comments reflect the intersectional nature of stigma and othering,⁴³ as the difficulty of her caring status is compounded by the responses from her community of origin, and her exclusion is intensified by her own mental distress derived from her caring

role. Despite this, the carers recognized that their own recovery journey was important, and they needed to think about their own needs.

PARTICIPANT5: "I learned I also need to take care of myself and learn from others about how to maintain boundaries and learn to pass on responsibilities to help us both."

The final theme relates to the need for carers to develop insight into their own situation and acknowledge their own needs, reflecting on the relevance of recovery to their own lives.

Evaluating the Training

At the post-intervention stage, the participants were asked to evaluate the training program responding to online open questions prepared through the Qualtrics software. For some, online learning was a very convenient mode of delivery:

PARTICIPANT 5: "The online learning experience of listening to and learning from other people was very useful. It was easier than having to find time off work or rushing on public transport or spending more money on taxis to get to and return from a venue and worry about my daughter. It is even safer now because of COVID to have online learning."

Being able to look back at the material was very important:

PARTICIPANT 4: "It was great having the ability to go over the PowerPoints. Preparing for virtual sessions beforehand."

Peer support was key to the effectiveness of the program, despite it being provided through virtual connections.

PARTICIPANT 5: "It helped greatly to listen to the experiences of other carers and the MH professional because it explained how everyone is on a journey and we have difficult times, but there is hope to understand each other better and find ways to enjoy our lives with the help of others when we need. It felt good to know we were not alone."

Participant 3 recognized both the good and bad features of online learning.

PARTICIPANT 3: "In some ways it was easier because removed barriers such as travel, but key challenge was feeling open/able to talk when person you care for is around."

However, online learning was experienced as difficult to find a safe place to participate in the course away from the service user; this was echoed by other participants.

The carers underlined some improvements for developing the content of the online program, highlighting the importance of understanding care settings (participant 4), and accessing carers' assessments (participant 5). Practical issues with the technology were also identified:

PARTICIPANT 5: “What I had typed as replies to the assessments. Also, when I had a break and returned to the learning, the system did not go to place where I had reached and it did not save anything I had written.”

The participants commented that it was helpful to have both a service user and a carer trainer.

PARTICIPANT 2: “JF’s [author 1, expert-by-experience facilitator] insight into the struggles of service users from her experience was priceless, and also she understood very well the challenges for the carers.”

PARTICIPANT 4: “So helpful to get two sides of their journeys.”

This section has highlighted the carers’ response to the online learning and reinforced that having both a carer- and a user-trainer delivering the training was highly valued by all carers.

Discussion

In the findings, three themes are highlighted that emerged inductively from the qualitative data: understanding recovery, supporting the recovery journey, and acknowledging carers’ needs and their own journey of recovery. This focus reflects the evidence base around the needs for carers to learn about recovery, underlining the potential of the course as an effective intervention, even though learning is informed by only a small sample.

From the pre-intervention point, recovery was understood as a return to pre-morbid functioning and as the alleviation of symptoms, as reflected in other studies.¹⁶ These results tie in with research undertaken by Quaye and Rennoldson, who investigated carers’ constructions of the meaning of recovery, and found that a medical interpretation of recovery predominated.¹⁶ This is not surprising, as recovery is often an ambiguous process and an outcome that is difficult to define.¹⁵

However, as the project progressed, the carers began to construct an individual understanding of recovery, as they related to their own circumstances and experiences of caring. This relates to research by Noiseux et al. who undertook a qualitative study comparing the perspectives of patients, family members/ friends, and care providers about recovery.⁴⁴ Their results suggest that conceptualization of the recovery process depends on constructing meaning around mental illness experiences based on individual’s dynamic context (e.g., social network, relationship), life experiences, and other social determinants (e.g., symptoms, environment), highlighting the individual understanding of recovery to each person. This finding is similarly reflected in this study as participation in the course allowed participants to explore the meaning of recovery. This study, with a small sample, thus validates the need to provide carers with a safe place to reflect on and understand their experiences because they may have had little opportunity to explore their caring status.

The second theme identifies the support that participants considered both they and professionals provided in sustaining the recovery journey of the service user. The carers recognized the importance of getting alongside and supporting the service user, engaging with a multitude of tasks to support their recovery.¹ The participants in this small sample expressed a sophisticated understanding of their role in the recovery process. Moreover, carers saw professional practice and medication as central to the recovery of the relative, a finding independently generated in many studies.^{22, 23} However, the carers in this study were often quite isolated from professional support for themselves and did not express the need to engage with other professionals. Despite this being only a small sample, this is surprising, as many studies^{7, 8, 21-23} highlight carers' beliefs about the importance of professionals involving them in the care of their relative. For example, Rowe has emphasized the importance of a covenant between carers, service users, and professionals, setting out the expectations of each participant in this triad⁴⁵; and the well-known triangle-of-care underlines the importance of a three-way cooperative relationship between these actors.⁴⁶

Furthermore, in other studies, the provision of professional support has been identified as key to the well-being of carers. It is reported that carer engagement with health care professionals impacted on their experiences of agency and fostered a greater feeling of control for carers over the difficulties experienced by the service user.⁴⁷ Although only a small study, the carers in this study seemed to be reticent about their own needs for professional interventions in their caring role. However, notwithstanding these assertions of the need for carer involvement in their relative's support, it must be acknowledged that service users retain the right not to involve relatives, family members, or friends in their care, and moreover, can displace their identified carer as the nearest relative (a legal role undertaken by family carers) under the amendments to the English Mental Health Act⁴⁸; furthermore, not all family carers support recovery in a positive way.

The final theme relates to recognizing the carers' own needs and how they think about their own journey of recovery. When the participants considered their own needs, and their own journey of recovery, they did not question their obligations to care. Rowe acknowledges that professionals also rarely question this duty but often do not acknowledge a carer's right for support in this role.⁴⁵ This suggests a gap between the expectations that professionals have of carers and the provision of support available to help them to care. Moreover, caring can be a very lonely journey as, for example, one participant experienced associative stigma from being a carer⁴⁰ and encountered her own mental distress through her sense of exclusion by her community of origin.

It was important to encourage the carers to think about their own recovery; therefore, they were introduced to the COOL recovery model, which is an early example of a recovery model for carers produced by carers themselves.⁴⁹ COOL recovery notes the possibilities of positively rebuilding the carer's identity and of having their own opportunities for recovery.⁴⁹ This underlines the importance for carers to experience their own journey of recovery, which is a mutual but separate recovery journey for both the service user and the carer.⁸ This suggests the need to consider both the service users' and the carers' journeys of recovery.

Learning about recovery can be beneficial for carers as it reinforces the need to convey hope and optimism as they care for the person they support.¹⁴ Moreover, understanding recovery as a journey with ups and downs, forwards and backwards, not just a linear process, gives them an insight into the nature of mental distress with times of circularity as well as forward progression in their journey.⁴¹ Understanding the nature of service provision and sharing their experiences with other carers helps them to relate to the role of professionals alongside that of the support they also provide.⁹

The Impact of COVID-19

As highlighted already, this course required us to move the blended learning format to an entirely online platform. Such adaptation, although unfortunate in disrupting our original study plan, enabled us to evaluate the move to a fully online delivered program. With the emergence of COVID-19, many interventions are now delivered online, from psychological interventions, as in our local mental health trust, to the delivery of social care assessments and support.⁵⁰ Moreover, many service providers consider that health and social care interventions will be increasingly delivered online as this format can save staff time and resources,⁵⁰ and return to face-to-face consultation and intervention will either be reduced or replaced by remote contact. This suggests the timeliness of this pilot in accordance with D&I science.¹²

Moreover, in their evaluation, the participants found the training beneficial in allowing them to explore their own role as carers in the recovery journey of their relative and to also consider their own pathways of recovery. The evaluation in this training program reflected the findings in the literature. The carers noted how the variety of synchronous and asynchronous learning allowed them to absorb the training. Campbell et al. highlight that the format of a blended learning course in an academic context should enable students to engage and learn through “synchronous and asynchronous methods of scaffolding knowledge” through “self-direction and collaborative learning”; this reflects the participants’ comments about engaging on more than one occasion with the learning material.⁵¹ Moreover, in a university setting, Bauman et al. underlined the flexible benefits of online learning for students but noted the difficulties faced when building a community of practice between participants.⁵² Although as in this study, combining both synchronous online and asynchronous e-learning has been found to facilitate increased peer support and peer discussion;³² the synchronous learning in a small group enabled the participants to collaborate on their learning as exemplified in other studies.²⁹ These findings thus highlight the potential of this course, which will need further implementation and evaluation.

Limitations

This training program study was piloted with a small group of carers and evaluated using mainly qualitative data. The emergence of COVID-19 impacted on the recruitment of the sample. The small sample size limits the validity of the evaluation and the findings reported from participation in the intervention. Additionally, not all participants who

completed the course engaged with all sessions. This makes it difficult to report the fidelity of the intervention. These limitations may be due to the lockdown experiences in the UK of 2020/2021, which impacted heavily on lifestyles at the time. Methods to improve better engagement with the participants should be investigated. Moreover, the program format and content need further evaluation because the course was delivered via online learning rather than through the blended learning process incorporating face-to-face contact as intended. Moreover, the delivery of the training program should be replicated with a larger group of participants. In the future, it would be helpful if the participants in a further study could be supported into the long-term to practise recovery through their caring, potentially through attendance at an ongoing support group that reinforces their learning about the dynamics of family relationships⁵³ or such processes as shared decision-making in mental health.⁵⁴

However, the online delivery of the evaluation also formed an interesting element of this study. It had been intended to undertake face-to-face focus groups to evaluate the course. An entirely online evaluation allowed us to explore how effective such evaluation may be when placed alongside online learning. It is reported that many participants do not respond effectively to invitations to participate in online surveys;⁵⁵ although these limitations are more often linked to surveys undertaken entirely online with large samples, and less so with qualitative research with a small sample-based study. Moreover, the online delivery of the evaluation caused some problems of engagement as carers struggled with some elements of the technology. This suggests that this is an area for further investigation from this pilot. Additionally, the use of SCORE-15 as a more prominent measure could be investigated for its potential to evaluate change in family function for a larger cohort of participants following therapeutic intervention. This suggests the need to adapt and replicate the intervention and subsequent evaluation considering the identified limitations.

Conclusion

In England, NICE has highlighted the importance for carers to have access to training programs that provide “a balance between learning, enjoyment, a chance to meet other carers and opportunities for peer support” (p. 25).³ This course has focused on enabling carers to understand recovery and utilize skills based on such a perspective, building on research previously undertaken by the first author,⁷⁻⁹ through the medium of an online course, adapted in response to the COVID-19 pandemic. This focus on learning a new approach was unique to these carers’ experiences of this training program.⁷

The participants found recovery to be a helpful concept enabling them to view the service user’s journey with more hope and optimism, seeing the importance of supporting them to set their own goals. Their understanding of recovery led to them defining recovery within a personal construct⁴⁴ and they began to recognize the importance of their own journey of recovery.⁴⁹

The online learning format of this piloted intervention was found to be effective as it enabled training to be convenient at times chosen by the participant;³⁰ moreover, it focused on reinforcing positive messages with a mixture of online synchronous and

asynchronous learning.²⁵ The perspectives of the co-trainers, JF and AS, allowed the carers to encounter recovery and connect with its potential. The participants' response to the unique partnership delivering the training sums highlights the distinctive focus of this program:

PARTICIPANT5: "The personal experiences of a service user and carer trainer were very important because I felt I could trust them because they were honest and spoke about different stages of their lives. The authentic voice of a person from each side of the relationship was important in giving us different perspectives on the challenges faced by both."

Finally, the current context, impacted by the COVID-19 pandemic, has interrupted both the intended mode and format of the intervention and the evaluation methods. However, the findings of this pilot study are interesting; moreover, the results endorse the implementation of a comprehensive study to explore further the potential benefits from participation in this intervention for this population of carers.

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