

Predictors of the Impact of Rights- and Recovery-Oriented Training for Mental Health Professionals

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Abstract

Objective: This study examines the factors influencing the effectiveness of a rights- and recovery-based training program for mental health professionals. **Methods:** From an initial pool of 643 professionals providing informed consent, 218 (33.9%) attended the training activity and completed the first follow-up assessment. Effectiveness was evaluated using a scale measuring beliefs and attitudes toward service users. Potential predictors included gender, age, experience, ideological orientation, education, profession type, personal or close experience with mental distress, and training satisfaction. **Results:** Interactions showed that profession type and personal experience moderated changes in coercion, with social professionals showing a sharper initial reduction that stabilized, clinical professionals a slower but more continuous decrease, and those without personal experience demonstrating greater overall reductions. Ideology moderated changes in paternalism, with left-leaning professionals showing a consistent decline and right-leaning professionals an initial decrease followed by an increase. **Conclusions and Implications for Practice:** These findings highlight the training's broad impact on beliefs and attitudes and the role of key professional characteristics in shaping specific outcomes, suggesting strategies for tailoring recovery-oriented education to diverse professional profiles. Further research should refine study designs, improve assessment tools, and explore behavioral outcomes to deepen our understanding of the mechanisms underlying training effectiveness.

Impact and implications statement

This study found that a rights- and recovery-based training program improved mental health professionals' beliefs and attitudes toward service users' rights. Social professionals showed a sharper initial reduction in coercive attitudes that later stabilized, while clinical professionals exhibited a slower but more continuous decrease. Professionals without personal experience with mental distress showed larger reductions in coercive attitudes, while left-leaning professionals reduced more their paternalistic attitudes. These findings can inform the design of targeted training to better promote recovery-oriented care.

Keywords: attitudes; beliefs; effectiveness; recovery-oriented care; rights-based care

Historically, mental health systems often relied on hierarchical, top-down structures, with policymakers and health care managers driving decisions (Davidson, 2016; Le Boutillier et al., 2011). This paradigm resulted in professionals making unilateral decisions, often disregarding service users' preferences, promoting dependency, and perpetuating disempowerment, which potentially hindered recovery and diminished caregivers' quality of life (Carbonell et al., 2020). Additionally, perceived stigma from health care providers contributed to internalized stigma among individuals receiving mental health care, reinforcing feelings of shame, low self-worth, and reluctance to seek help (Henderson et al., 2014; Wang et al., 2018). In response to these concerns, the recovery model (Anthony, 1993) emerged and gained prominence in the 1990s as part of the broader movement toward person-centered care (K. M. Wong & Cloninger, 2010). These movements promoted equal collaboration between health care providers and service users fostering shared decision-making (Drake et al., 2009; Hamovitch et al., 2018).

Person-centered and recovery-oriented approaches were not intended to limit clinicians' involvement but rather to empower individuals to lead fulfilling, hopeful, and meaningful lives, despite ongoing mental health challenges (Anthony, 1993). As recovery progresses, service users should be encouraged to take greater autonomy, collaborating with professionals who provide guidance and options (Matthias et al., 2012; Slade, 2009), ensuring that all individuals are recognized as active participants in their care, regardless of severity (Beyene et al., 2019). With the arrival of the Convention on the Rights of Persons with Disabilities (United Nations, 2006), human rights-based approaches definitely reframed service users as active participants, prioritizing dignity, respect, and equitable access to mental health care (Mann et al., 2016).

Training as a catalyst for transformation

Achieving meaningful change required mental health professionals to shift from authoritative, paternalistic roles to collaborative partners, adopting transparent, strengths-based practices that promote autonomy and empowerment among service users (Rabenschlag et al., 2014). In this context, professional training played a key role in transforming attitudes and beliefs among practitioners, contributing to broader cultural and systemic change (Crowe et al., 2006; Tsai et al., 2011).

Various research efforts have explored the contents and functions of training activities in mental health. Collectively, these studies highlight the importance and effectiveness of targeted educational interventions in enhancing mental health professionals' knowledge, attitudes, and skills related to recovery-oriented care (Mabe et al., 2016). Approaches such as simulated interactions and peer-led education have been particularly effective in boosting confidence and sustaining positive attitudes toward mental health recovery (Boukouvalas et al., 2018; Sreeram et al., 2024). Overall, the implementation of recovery-oriented training in clinical settings has been shown to improve staff knowledge, attitudes, and satisfaction (Hornik-Lurie et al., 2018; Nardella et al., 2021; Walsh et al., 2017; Williamson et al., 2023). Systematic reviews and meta-analyses (Eiroa-Orosa & García-Mieres, 2019; Gee et al., 2017; Lorien et al., 2020; McPherson et al., 2021; Sreeram et al., 2021) further demonstrate the impact of recovery training on the beliefs and attitudes of mental health professionals, though the effect on user and service-level outcomes remains unclear (Eiroa-Orosa & García-Mieres, 2019; Jackson-Blott et al., 2019). Overall, these findings illustrate the various benefits of comprehensive and context-specific mental health training programs and underscore the importance of further exploration and investment in such activities (Beyene et al., 2019; Gee et al., 2017; Jackson-Blott et al., 2019).

While the overall effectiveness of recovery-oriented training in mental health services is well established, less is known about the factors that shape its success across diverse professional groups. Few studies have systematically examined how individual characteristics, such as gender, profession, experience, or ideological orientation, shape the uptake of training content, limiting the ability to design tailored interventions that could maximize impact. Identifying these variables can inform the design of more impactful training initiatives, ultimately fostering meaningful and sustained improvements in practice (Cowman & McCarthy, 2016; Jackson-Blott et al., 2019).

The present study

This research examines the factors predicting the impact of a rights- and recovery-oriented training program designed for mental health professionals (Eiroa-Orosa, 2023). The intervention aimed to shift beliefs and attitudes toward recovery and service users' rights. To explore the factors influencing the effectiveness of rights- and recovery-based training for mental health professionals, several hypotheses were developed. (H1) Female participants were expected to show greater increases in respectful, autonomy-supportive, and non-discriminatory attitudes, reflecting a potentially higher openness to change (Deprez et al., 2012), while (H2) older (Albert & Duffy, 2012; Visser & Krosnick, 1998) and (H3) more experienced (Henderson et al., 2014) professionals were expected to exhibit smaller shifts. (H4) Greater openness to change was anticipated among left-leaning professionals (Becker, 2020; Kossowska et al., 2023) and those with (H5) higher education (Álvarez-Huerta et al., 2022). (H6) Social and non-clinical staff were expected to show a stronger shift toward respectful, person-centered care than clinical professionals, whose training in biomedical models may lead to a stronger emphasis on risk management and clinical competence (Cowman & McCarthy, 2016; Zamorano et al., 2022). Additionally, (H7) professionals with personal or close experience of mental distress were considered more likely to

exhibit greater shifts in attitudes due to increased empathy (Gilbert & Stickley, 2012; J. C. M. Wong et al., 2024). Finally, (H8) higher satisfaction with the training was also predicted to enhance its impact, as engagement fosters learning (Mason et al., 2013).

Methods

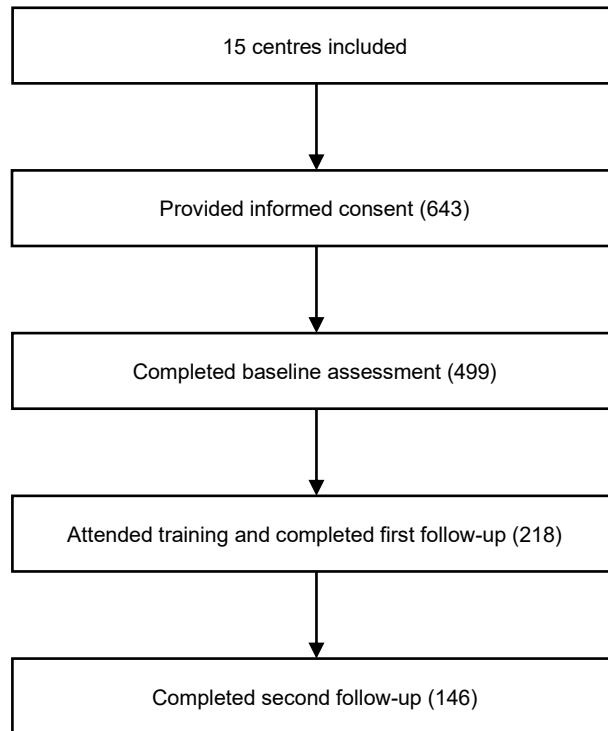
Design

This study employed a longitudinal, pretest-posttest design with two follow-up assessments. The design incorporated a single-group structure, with measurements conducted at three time points: baseline (pre-intervention), post-intervention (first follow-up), and 30 days post-intervention (second follow-up).

Participants

In total, 643 mental health professionals provided informed consent to participate in the study, with 499 (77.6%) completing the baseline assessment. Of these, 218 (43.7%) attended the training activity and completed the first follow-up assessment (post-intervention), and 146 (29.3%) completed the second follow-up assessment (30 days post-intervention). Participants were recruited from 15 mental health care centers located in the Spanish regions of Catalonia and Madrid, where the training was implemented. A convenience sampling procedure was used, as participation was voluntary and based on professionals' interest in the training sessions at their centers. Figure 1 illustrates the flow chart of the recruitment and follow-up process for all participants included in the study.

Figure 1.

Flow Chart of recruitment and completion

Of the 643 professionals who completed the baseline assessment, 79.25% were female, 88.1% had finished a higher education degree, and 44.66% worked in a social profession (in contrast to clinical professions). The mean age of the initial sample was 40.69 years (SD = 10.29), and the average professional experience was 12.99 years (SD = 8.63). Additionally, 25.7% of participants reported personal experience with mental distress, 80.6% reported close experience with mental distress, and the mean ideology score was 2.00 (SD = 0.82; 5-point Likert scale, 1 = left, 5 = right).

Procedure

Between 2017 and 2020, mental health professionals participated in this study. They were first informed about the study's objectives and structure and provided informed consent, which included agreeing to complete an online questionnaire. Participants then completed the baseline assessment. The first follow-up and a satisfaction questionnaire were scheduled two days after the training to capture immediate post-training changes in attitudes while minimizing recall bias. A final assessment was conducted 30 days later. The study protocol was approved by the University of Barcelona Bioethics Committee (IRB00003099) on October 8, 2015.

Intervention

The intervention consisted of an 8-hour training program delivered over two 4-hour days at each of the 15 participating mental health centers. Training sessions were held in-person at each center's facilities. The training was designed to enhance mental health professionals' understanding of recovery-oriented and rights-based care, reduce stigmatizing attitudes, and promote service user autonomy. The content was developed through a participatory process involving a literature review (Eiroa-Orosa & García-Mieres, 2019) and focus group conducted prior to the study. Eighteen focus groups, comprising mental health professionals (e.g., clinical psychologists, nurses, psychiatrists, social workers, etc.) and service users with lived experience of mental health challenges, were held to identify key themes related to stigma, recovery, and rights in mental health care (Eiroa-Orosa & Pradillo-Caimari, 2024). Thematic analysis of these focus groups informed the training curriculum, ensuring it addressed real-world challenges and incorporated diverse perspectives. The training covered four core topics (Eiroa-Orosa, 2023): The first focused on alternatives to diagnosis and stigma. In the second topic, the emphasis was on goal setting, transitioning from symptom reduction to recovery. The third topic centered on rights-based

mental health care, emphasizing collaborative practices, preferences, and advance directives. Lastly, the fourth topic aimed to promote peer support by integrating lived experience into the mental health care system.

The mode of delivery combined multiple instructional modalities to engage participants and facilitate active learning. Each session included didactic lectures (approximately 60% of the time) to provide theoretical foundations, and interactive activities (40%) to discuss case studies and apply concepts. These modalities were selected based on evidence that interactive learning strategies, such as action and reflection, are effective for training mental health professionals (Beidas & Kendall, 2010).

Attendance at the training was voluntary and offered as a professional development opportunity to mental health professionals at the participating centers. Invitations were extended through center administrators, and interested individuals registered without obligation. While participation in the training was voluntary, all attendees were invited to participate in the study evaluating the training's effectiveness, though study participation was also voluntary and required separate informed consent. Of the professionals who attended the training, 93% agreed to participate in the study, ensuring a high but not complete overlap between training attendees and study participants.

The training was delivered by a team comprising two psychologists with expertise in recovery-oriented care and six peer-facilitators, all eight of whom had lived experience of severe mental health distress. Fidelity to the curriculum was maintained through a training-of-trainers program led by the first author, who also served as a facilitator for the theoretical content. The team delivered the training at all 15 centers maintaining consistency in content and delivery, with minor adaptations to address center-specific contexts (e.g., incorporating discussions of local

policies into the workshops). The first author was present at all training sessions to provide direct oversight and ensure adherence to the curriculum.

Measures

To measure the effectiveness of the training activity, the Beliefs and Attitudes Toward Mental Health Service Users' Rights Scale (BAMHS; Eiroa-Orosa & Limiñana-Bravo, 2019) was selected as the primary outcome measure. The BAMHS was chosen because it is a validated instrument specifically designed to assess changes in mental health professionals' beliefs and attitudes toward service users, directly aligning with the training's objectives of promoting rights-based and recovery-oriented care. The BAMHS consists of 25 items rated on a 4-point Likert scale, with higher scores indicating greater endorsement of attitudes associated with rights restrictions, stigma, and reduced autonomy for service users. The scale has demonstrated good reliability Cronbach's alpha ranging from .722 to .867 for the total score in previous studies (Eiroa-Orosa, 2023; Eiroa-Orosa et al., 2021) and validity in prior research (Eiroa-Orosa & Limiñana-Bravo, 2019). The BAMHS comprises four theoretically derived subscales, developed to capture distinct dimensions of attitudes toward mental health service users' rights. The first, *Justification beliefs*, focuses on mental health professionals' views on maintaining the status quo, including beliefs about mental disorders, aggression, rights, and the likelihood of recovery without professional help. The *Coercion* dimension examines attitudes toward involuntary admission, mechanical restraints, and respect for service users' autonomy. *Paternalism* reflects beliefs assuming that persons diagnosed with mental disorders cannot manage their lives, including decisions about treatment and personal choices. *Discrimination* assesses prejudices towards mental health service users, such as voting rights and comfort with their participation in everyday roles.

Socio-demographic data were collected, including gender, educational level, profession type, personal or close contact with mental disorders, age, years of experience, and ideological orientation. Personal experience was coded as ‘yes’ if participants reported having personally experienced mental distress. Close experience was coded as ‘yes’ if participants reported a family member or close acquaintance with mental distress. Ideology was measured using a 5-point Likert scale from 1 (definitely left) to 5 (definitely right), a reliable proxy for self-reported ideology in cross-national survey research (De keersmaecker et al., 2024). Within the regional context of this study, professions were divided into two categories: social and clinical. Social professions, such as case managers, occupational therapists, and social workers, focus on psychosocial support, community integration, and rehabilitation. In contrast, clinical professions, including nurses, psychologists, and psychiatrists, primarily handle therapeutic interventions, such as diagnosis, treatment implementation, and medication management.

Following the training, participants completed a satisfaction questionnaire (10 items rated on a 5-point Likert scale from 1 to 5) covering aspects such as organization, teaching methodology, teacher knowledge, topic interest, practical applications, time allocation, and materials used.

Statistical analysis

The reliability of the BAMHS was assessed using Cronbach’s alpha for the total scale and each subscale at baseline, first follow-up, and second follow-up. To examine attrition, baseline demographics and BAMHS scores of participants completing the first and second follow-ups were compared with those who did not, using chi-square tests for categorical variables and *t*-tests for continuous variables. Bivariate correlations were computed to assess relationships between covariates, using Pearson’s correlation for continuous variables, point-biserial correlations for associations between continuous and dichotomous variables, and phi coefficients for associations

between two dichotomous variables. Repeated measures multivariate analyses of variance (RM-MANOVAs) and covariance (RM-MANCOVAs) evaluated the training's effect on the four BAMHS subscales across three time points (baseline, first follow-up, second follow-up) and its interaction with the covariates. All covariates were initially included, then iteratively removed if $p > .05$ or partial eta squared $< .03$ for all multivariate and univariate analyses. Wilks' Lambda assessed multivariate effects, and interaction terms between these covariates and time were tested to assess moderation. Normality was tested using Shapiro-Wilk tests, and Mauchly's test assessed sphericity. Significance was set at $p < .05$, with effect sizes reported as partial eta squared. To address missing data at the second follow-up, multiple imputation was implemented using baseline and first follow-up BAMHS scores as predictors. We generated 5 imputed datasets, which were pooled for analysis using Rubin's (1987) rules.

Results

Attrition

Attrition analyses revealed no statistically significant differences in baseline demographics or BAMHS scores between participants completing the first and second follow-ups and those who did not, except for profession type, with social professionals more likely to complete both follow-ups (first: OR: 1.542, 95% CI [1.044, 2.278], $p = .029$; second: OR: 1.694, 95% CI [1.125, 2.552], $p = .029$).

Reliability

Cronbach's alpha values for the BAMHS ranged from .823 to .861 for its total score. The following ranges within the points of data collection in Cronbach's alpha values were observed for the subscales: beliefs $\alpha = .664$ to $.712$, coercion $\alpha = .529$ to $.621$, paternalism $\alpha = .661$ to $.718$, and discrimination $\alpha = .528$ to $.671$.

Exploration of bivariate correlations between covariates

Table 1 summarizes bivariate correlations among covariates. A strong correlation was found between age and years of experience ($r = .770, p < .001$). Therefore, to prevent multicollinearity in the multivariate analyses of variance, age and years of experience were introduced in separate models.

Repeated measures analysis of the variance and covariance

A RM-MANOVA without covariates revealed a significant multivariate effect of time across all BAMHS subscales, with univariate analyses confirming statistically significant reductions in all subscale scores over the three time points.

Following the procedure detailed in the analysis section, age, years of experience, close experience, satisfaction with the training, education, and gender were removed from the model due to p -values exceeding .05 and partial eta squared values below .03 across all multivariate and univariate tests. Age and years of experience did not independently contribute significant effects when included separately in the models. In contrast, profession type, having a personal distress experience, and ideological orientation met the retention criteria, demonstrating statistically significant interactions with time ($p \leq .05$) and/or effect sizes $\eta^2_p \geq .03$ in either multivariate or univariate tests.

Within the final RM MANCOVA model multivariate within-subject tests (Wilks' Lambda) showed no statistically significant main effect of time, $F(8, 406) = 0.554, p = .815, \eta^2_p = .011$, indicating no overall change in BAMHS subscales across time points when including the covariates in the model. However, statistically significant interactions were found for time \times

personal experience, $F(8, 406) = 2.093, p = .035, \eta^2_p = .040$, and time \times ideology, $F(8, 406) = 2.516, p = .011, \eta^2_p = .047$.

Univariate tests, adjusted for non-sphericity using Greenhouse-Geisser corrections where Mauchly's test was statistically significant (Beliefs: $W = .815, p < .001$; Discrimination: $W = .806, p < .001$), revealed no statistically significant main effects of time on any subscale. However, statistically significant interactions were found for time \times profession type on Coercion, $F(2, 206) = 3.766, p = .025, \eta^2_p = .035$, with a quadratic trend, $F(1, 103) = 6.93, p = .010, \eta^2_p = .063$, indicating that social professionals showed a sharper initial reduction in coercive attitudes that leveled off, whereas clinical professionals displayed a slower but more continuous decrease over time. The time \times personal experience interaction was statistically significant for Coercion, $F(2, 206) = 6.740, p = .001, \eta^2_p = .061$, with a linear trend, $F(1, 103) = 10.50, p = .002, \eta^2_p = .081$, showing greater reductions in Coercion scores for participants without personal experience with mental distress, who began with higher scores. The time \times ideology interaction was statistically significant for Paternalism, $F(2, 206) = 5.616, p = .004, \eta^2_p = .052$, with a quadratic trend, $F(1, 103) = 10.37, p = .002, \eta^2_p = .091$, indicating that right-leaning participants, who started from higher levels, showed an initial decrease followed by an increase in Paternalism scores, whereas left-leaning participants exhibited a consistent decline. Results are summarized in Table 2, while the three reported univariate interactions are plotted in Figure 2.

Table 1

Correlations within the covariates

	Gender	Education	Profession	Close	Personal	Age	Experience	Ideology	Satisfaction
Gender	1.000								
Education	0.019	1.000							
Profession	-0.009	0.292***	1.000						
Close	0.019	-0.048	-0.009	1.000					
Personal	-0.108*	-0.032	-0.030	0.182***	1.000				
Age	0.080	0.002	0.049	-0.108*	-0.083	1.000			
Experience	0.056	0.096	0.197***	-0.186***	-0.059	0.770***	1.000		
Ideology	-0.136*	-0.094	0.072	0.067	0.036	-0.079	-0.096	1.000	
Satisfaction	-0.047	-0.061	-0.109	-0.002	0.050	-0.004	-0.024	-0.104	1.000

Note: *** Correlation is significant at the .001 level (2-tailed). ** Correlation is significant at the .01 level (2-tailed). * Correlation is significant at the .05 level (2-tailed). Pearson's correlations were computed for associations between two continuous variables, point-biserial correlations for associations between continuous and dichotomous variables, and phi coefficients for associations between two dichotomous variables. Categorical covariates were coded as follows: gender (1 = female, 2 = male), education (1 = non-higher education degree, 2 = higher education degree), profession type (1 = social, 2 = clinical), close experience with mental distress (1 = yes, 2 = no), personal experience with mental distress (1 = yes, 2 = no), age (age in years), experience (experience in years), ideology (1 = definitely to the left, 2 = rather to the left, 3 = center, 4 = rather to the right, 5 = definitely to the right).

Table 2

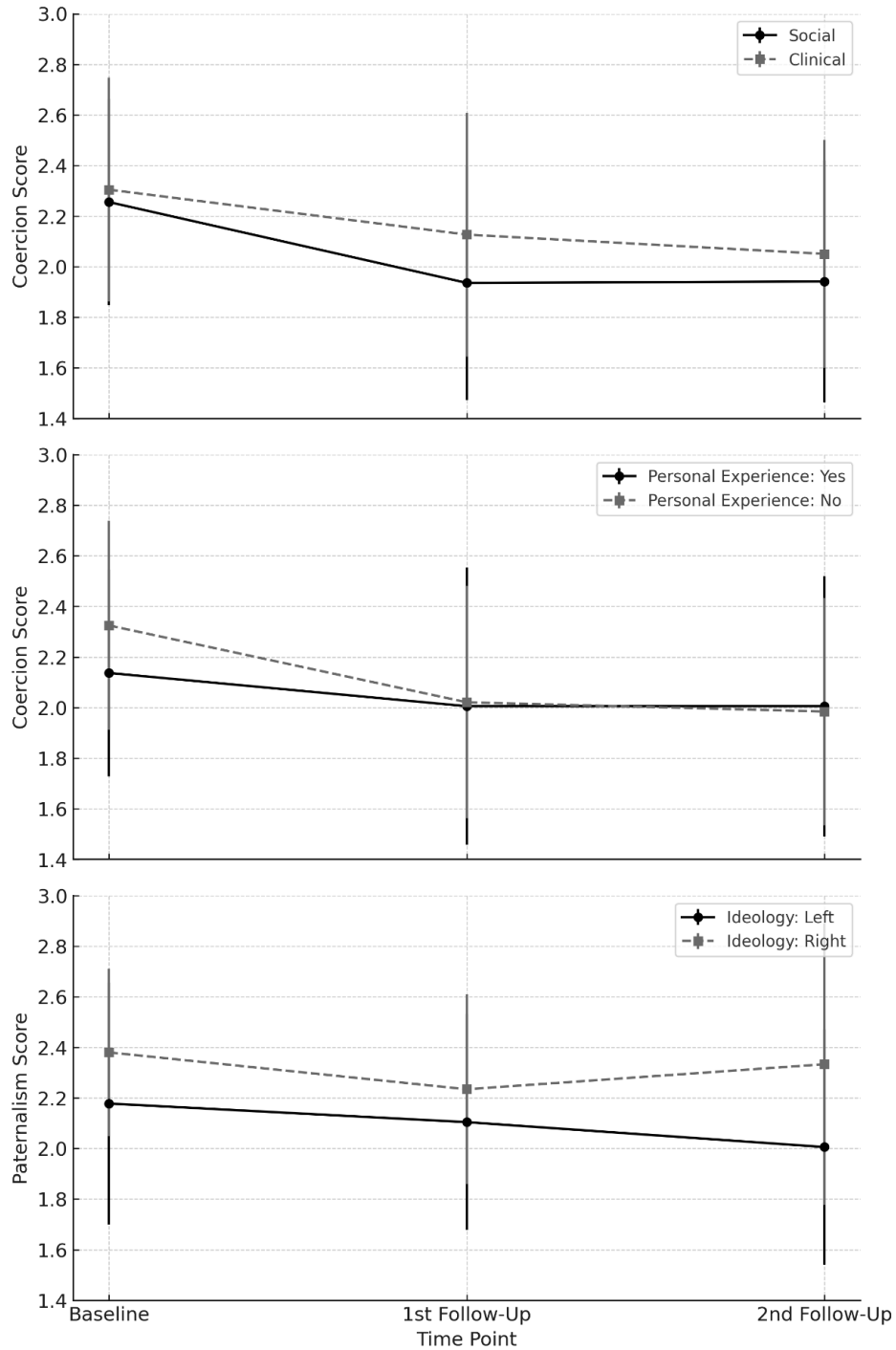
Multivariate and univariate interaction effects of time with profession type, personal experience, and ideology on BAMHS subscales across three time points

Analysis/Subscale	Λ	F	p	η^2_p
RM-MANCOVA				
Profession type	.945	1.457	.171	0.028
Personal experience	.922	2.093	.035	0.040
Ideology	.908	2.516	.011	0.047
Beliefs				
Profession type		1.559	.216	0.015
Personal experience		1.835	.169	0.018
Ideology		2.399	.103	0.023
Coercion				
Profession type		3.766	.025	0.035
Personal experience		6.740	.001	0.061
Ideology		0.767	.466	0.007
Paternalism				
Profession type		1.847	.160	0.018
Personal experience		0.308	.735	0.003
Ideology		5.616	.004	0.052
Discrimination				
Profession type		0.511	.568	0.005
Personal experience		0.848	.412	0.008
Ideology		0.065	.910	0.001

Note: The analysis includes 107 participants with complete data. Multivariate results are based on Wilks' Lambda (Λ). Univariate results for Coercion and Paternalism assume sphericity ($p \geq .05$, Mauchly's test), while Beliefs and Discrimination use Greenhouse-Geisser corrections ($p < .001$). Degrees of freedom are multivariate: $F(8, 406)$; univariate: $F(2, 206)$ for Coercion and Paternalism, $F(1.688, 173.883)$ for Beliefs, and $F(1.674, 172.467)$ for Discrimination.

Figure 2.

Interactions of time with profession type, personal experience, and ideology on coercion and paternalism subscales



Note: Error bars represent standard deviations.

Using multiple imputation across five datasets, we confirmed the consistency of the univariate test results with slightly lower effect sizes in the pooled estimates. Statistically significant interactions were observed for time \times profession type on Coercion ($F = 3.222$, $p = .040$, $\eta^2_p = .022$), time \times personal experience on Coercion, ($F = 4.682$, $p = .012$, $\eta^2_p = .040$), and time \times ideology on Paternalism, ($F = 3.454$, $p = .038$, $\eta^2_p = .032$).

Discussion

This study examined the predictors of impact for a rights- and recovery-oriented training program designed for mental health professionals, focusing on how gender, educational level, profession type, personal or close experience with mental distress, age, years of experience, ideological orientation and satisfaction with training influenced changes in beliefs and attitudes toward service users' rights. The training influenced attitudes across all BAMHS subscales, including *justification beliefs* and *discrimination*, but these two domains showed no significant interactions with any covariate. This suggests that the training's impact on beliefs about recovery and discrimination was consistent across diverse professional groups. In contrast, the findings highlight interactions involving profession type and personal experience with mental distress in shaping attitudes toward coercion, and ideological orientation in shaping attitudes toward paternalism. These interactions offer insights for tailoring training to diverse professional profiles.

Clinical professionals exhibited a continued but less pronounced reduction in coercive attitudes compared to social professionals, who showed a more substantial decrease from baseline to the first follow-up before stabilizing. This pattern supports the hypothesis that biomedical training may emphasize risk management (Cowman & McCarthy, 2016; Zamorano et al., 2022), yet suggests that social professionals, potentially due to their psychosocial focus, may respond

more rapidly to rights-based training, with clinical professionals showing gradual shifts toward person-centered care (Lorien et al., 2020). In contrast, professionals without personal experience of mental distress exhibited more pronounced reductions in coercive attitudes, refuting the hypothesis that lived experience enhances receptivity to rights-based principles for this domain (Gilbert & Stickley, 2012; J. C. M. Wong et al., 2024). This suggests that those without personal experience, starting with more coercive attitudes, may have greater room for attitude change following training. For paternalism, left-leaning professionals demonstrated greater reductions compared to their right-leaning peers, supporting the hypothesis that ideological alignment with social justice values facilitates attitude change (Becker, 2020; Kossowska et al., 2023). These findings underscore the importance of considering professional background, personal experiences with mental distress, and ideological orientation when designing training programs to maximize their impact.

The study was conducted in Spain, within a mental health system transitioning from biomedical models to recovery-oriented and rights-based care, influenced by policy reforms aligned with the UN Convention on the Rights of Persons with Disabilities (Eiroa-Orosa & Rowe, 2017; Spanish Ministry of Health, 2021). This context likely shaped the training's reception, as professionals navigated a system where traditional practices coexist with emerging person-centered approaches. The training's focus on reducing coercive and paternalistic attitudes may resonate particularly well in this context, given the ongoing need to align professional practices with policy reforms. However, the Spanish context, with its universal health care system and regional variations in mental health service delivery, may limit the generalizability of findings to other countries with different health care structures or cultural attitudes toward mental health.

Several limitations should be considered when interpreting the findings. The moderate reliability of the Discrimination subscale may have obscured potential effects, suggesting a need for improvement of the measurement tool. With fewer items, each item's variance may have a larger impact on the total score, increasing measurement error and reducing reliability (Niemi et al., 1986). Additionally, the high attrition rate at follow-up assessments may have reduced the ability to detect consistent effects across all participants (Kang, 2013). Attrition may be explained by workload pressures, scheduling conflicts, and the voluntary nature of participation in both the training and the study. Nevertheless, attrition analyses showed no significant differences in baseline demographics or attitudes between completers and non-completers, except for profession type, with social professionals being more likely to complete follow-ups and showing a distinct trajectory in reducing coercive attitudes. Furthermore, the non-experimental design limits causal inferences about the predictors' effects, as unmeasured factors like workplace dynamics could play a role (Bergh, 1995). Future studies would benefit from including a control group to better isolate the effects of the training and strengthen causal inferences. The effect sizes for interactions were small, although consistent with those reported in other mental health training interventions (Eiroa-Orosa & García-Mieres, 2019). Despite their size, these effects may have meaningful practical implications, as even modest changes in professionals' attitudes can strengthen the recovery orientation of services (Gee et al., 2017). Moreover, the sample's ideological bias, with fewer right-leaning participants, may reflect self-selection, as the training's social justice focus aligns more with left-leaning values, potentially affecting the representativeness of the sample (Kossowska et al., 2023). In addition, while demographic variables were controlled for, other unmeasured factors, such as staff workload and post-training understanding of recovery-oriented care, could influence the results (Chatwiriyaiphong et al., 2024). Likewise, volunteer bias (Campbell & Gallagher, 2007),

reliance on self-reported measures (Rosenman et al., 2011), and the use of ad-hoc dichotomized variables (Naggara et al., 2011) may have introduced ambiguities or overlooked nuances. Finally, the study focused on short-term attitudinal outcomes rather than long-term behavioral changes, limiting insights into how predictors influence practical applications.

Conclusion

The findings highlight profession type, personal experience with mental distress, and ideology as critical predictors of the impact of rights and recovery-oriented training, particularly in reducing coercive and paternalistic attitudes among mental health professionals. These insights emphasize the value of tailoring training to professional roles, experience levels, and ideological perspectives to enhance effectiveness. Future research should use refined measurement tools and study designs, address attrition, and expand to larger, more diverse samples to strengthen reliability and generalizability. Incorporating behavioral outcome measures would offer a clearer understanding of how participants apply training content in practice. From a practical standpoint, training programs should include preintervention assessments to identify barriers, staff attitudes, and organizational dynamics. Contextual factors such as motivation, leadership style, and workplace uncertainty can influence the impact of training and should inform program development. At a broader level, integrating structured and evidence-based training into ongoing professional development frameworks, with continued support for implementation, can foster sustainable improvements in rights based and recovery-oriented care and contribute to meaningful change at individual, team, and organizational levels.

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