

Defining and Measuring Principles for Recovery-Oriented Care in Mental Health Organizations

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Principal Aims of Talk

1. Enumerate background, theoretical and empirical underpinnings, and principles of recovery-orientation
2. Describe development of organization-level recovery scale
3. Report quantitative findings from small pilot of scale

Outline

- Background on recovery vs. recovery-orientation
- Development process for Recovery-Oriented Practices Index
- ROPI Pilot data ($N = 4$)
- Implications and next steps

Background on Recovery and Recovery Orientation

- Recovery: What is it?
 - Two strains—mental health and substance abuse literature
 - Substance abuse recovery:
 - derived from 12-step
 - “in recovery” (i.e., fragile, requiring constant vigilance, provisional)
 - Primary criterion: control over use of substances

Background on Recovery and Recovery Orientation

- Mental health recovery:
 - Traces to consumer-survivor literature and prominent longitudinal studies on recovery (e.g., Harding, Brooks, Ashikaga, Strauss, & Breier, 1987)
 - No single criterion—often self-determined
 - Multiplicity of definitions (Onken, Craig, Ridgway, Ralph, & Cook, in preparation)
 - *As process* (non-linear, personal journey, embrace of hope, overcoming effects of institutionalization)
 - *As outcome* (fulfillment of life roles, reduced involvement in formal services, greater self-agency)
 - *As transaction with environment* (rejection of “normal,” supportive relationships, impact of stigma, policy-making)

Background on Recovery and Recovery Orientation

- Despite varying definitions, a number of common themes have emerged¹:
 - *Identity formation* (mental illness one facet of a more differentiated self; see Deegan, 1996)
 - *Autonomy/self-agency* (greater capacity for self-initiated action; internal vs. external motivation)
 - *Hope* (renewed sense of possibility)
 - *Supportive-healing relationships* (both professional and personal)
 - *Enhanced role functioning* (employment, parenthood)

¹For an excellent review, see Davidson, O'Connell, Tondora, Lawless, & Tondora, (2005). *Recovery in Serious Mental Illness: A New Wine or Just a New Bottle. Professional Psychology, Research, and Practice*, 36, 480-487.

Background on Recovery and Recovery Orientation

Indeed, the process of recovery has been well-described...*but what are its implications for mental health organizations?*

One obvious implication is that organizations should seek to leverage their services to enhance these facets of recovery.

- But how?
- And is there evidence that recovery-enhancing strategies would work?

Background on Recovery and Recovery Orientation

“The fullest representations of humanity show people to be curious, vital, and self-motivated. At their best, they are agentic and inspired, striving to learn; extend themselves; and apply their talents responsibly... Yet, it is also clear that the human spirit can be diminished or crushed and that individuals sometimes reject growth and responsibility...”

Background on Recovery and Recovery Orientation

“The fact that human nature...can be either active or passive, constructive or indolent suggests more than mere dispositional differences...It also bespeaks a wide range of reactions to social environments...*Social contexts catalyze...motivation and personal growth.*” (Ryan & Deci, 2000)

Background on Recovery and Recovery Orientation

- Self-determination theory (SDT) provides a theoretical framework for recovery-orientation and empirical evidence to support its salutary role (Ryan & Deci, 2000):
 - A motivational theory of human need fulfillment
 - Posits three fundamental human needs: 1) autonomy, 2) competence, and 3) relatedness
 - Satisfaction of these needs promotes *well-being*, *feelings of security*, and *self-motivated* behavior

Background on Recovery and Recovery Orientation

- Empirical findings on SDT:
 - Behavioral management of diabetes is predicted by perceptions of an autonomy-supportive health care environment (Williams, McGregor, Zeldman, Freedman, & Deci, 2004)
 - Employees that report more need satisfaction (autonomy, competence, and relatedness) show better objective job performance (Deci et al., 2001).
 - Learning environments characterized by more autonomy support result in deeper processing of material, better test performance, and more persistence (Vansteenkiste, Simons, Lens, Sheldon, & Deci, 2004)
 - Enhancing autonomous motivation results in better treatment retention for substance abuse programs (Ryan, Plant, & O'Malley, 1995)
 - Many other studies have confirmed SDT's postulates

Background on Recovery and Recovery Orientation

- To reiterate, SDT identifies 3 basic needs:
 - *Autonomy, competence, and relatedness*
 - There are correlates of each need in mental health organizations' practices, services, policies

Background on Recovery and Recovery Orientation

- How can MH programs enhance autonomy?
 - Avoid restrictive interventions when possible (involuntary hospitalization; rep payee; outpatient commitment; restraints)
 - Promote client decision making (type of services, medications, housing)
 - Develop life goals (employment, relationships, hobbies)
 - Reduce client's sense of being a "patient" (mitigate often subtle incentives for dependency)

Background on Recovery and Recovery Orientation

- How can MH programs enhance feelings of competency?
 - Skills-based interventions (ADLs, work skills, social skills)
 - Employment
 - Self-management of mental illness (coping with symptoms)

Background on Recovery and Recovery Orientation

- How can MH programs enhance feelings of relatedness?
 - Family-based interventions (psychoed. groups, contact w/ family members)
 - Focus on community integration (non-mental health activities)
 - Fostering relationships among consumers (group outings; special events)

Background on Recovery and Recovery Orientation

- Self-determination theory provided broad theoretical framework for recovery-orientation
- But not specific organizational correlates of recovery
- For that, we turned to extant self-report scales that we could translate into an organization-level scale

	Provider-Determined		Consumer-Determined
	<u>Coercive</u>	<u>Paternalistic</u>	<u>Recovery-Oriented</u>
Program regulatory mechanisms	Contingencies (punishment focus) Enforced dependency	Contingencies (reward focus) Incentives for dependency	Non-contingent Incentives for autonomy and personal accountability
Associated practices	Mandated psychotropic medication Deficit-focus, Boilerplate treatment plans, Coercive treatments (threats of hosp., outpatient commitment, restraints) No consumer input on org. Minimal choice	Emphasis on medications Maintenance-focus Some individualization in treatment Clinician-driven treatment (with input from consumer) Pro forma mechanisms for consumer input Moderate choice (e.g., medication type)	Medications part of overall treatment plan Recovery-focus Individualized (e.g., consumer's own words) Consumer-driven (with input from clinician) Consumer input basic to org. Consumer as source of control
Impact on consumer's self-regulation	Non-intentional, Feelings of incompetence, Lack of control, Helplessness	Compliant, External motivation (based on other's expectations), Dependent	Self-agency Internal motivation Independent

Development Process for Recovery-Oriented Practices Index

Six steps:

- 1) Consumer/researcher working group identified 11 prior self-report recovery scales and 4 typologies of recovery practice*
- 2) Content analysis of items
- 3) Classification of items into thematic groupings (e.g., consumer involvement in treatment, use of self-help, family involved in services, employment services)
- 4) Further refinement of groupings based on latent content (e.g., choice, community integration)
- 5) Comparison of groupings with previous recovery typologies (esp. New York State consumer white paper: *Infusing Recovery-Based Principles into Mental Health Services*)
- 6) Development of principles of recovery-orientation based on latent content classification scheme

*The Health Services Research Institute and Theodora Campbell provided invaluable help in identifying and classifying scales; listing of scales is available from first author

Development Process for Recovery-Oriented Practices Index

Eight principles of recovery-oriented care resulted:

1. **Meeting basic needs** - assessment, planning, and delivery of all services should first address basic needs, including shelter, food, health, clothing, and entitlements
2. **Comprehensive services** – full range of treatment services using different modalities (individual, group, peer)
3. **Customization and choice** – all services should be designed to address the unique circumstances, history, needs, expressed preferences, and capabilities of each consumer
4. **Consumer involvement and participation** – consumer involvement and participation should be integral to the planning and delivery of all services and to the determination of policies and procedures for program operations.

Development Process for Recovery-Oriented Practices Index

5. **Network supports/community integration** – active efforts in the planning and delivery of services to involve environmental supports and promote non-mental health activities in the consumer’s recovery.
6. **Strengths-based approach** – service delivery and planning should be fundamentally oriented toward consumer’s strengths rather than deficits.
7. **Self-determination** – development of autonomous motivation and feelings of self-agency should be integral to program philosophy, with minimal reliance on coercive treatment alternatives.
8. **Recovery focus** – services should be oriented toward life roles, client aspirations, and independence from services, including techniques for self-management of mental health symptoms, development of meaningful activities, and assistance with employment, parenthood, and romantic relationships.

Development Process for Recovery-Oriented Practices Index

- Principles were operationalized into 5-point behaviorally-anchored response alternatives
- Modeled on fidelity scales
- Result was Recovery-Oriented Practices Index (ROPI), a 17-item scale (*see handout*) based on the 8 principles
- Assessed 4 primary aspects of program functioning:
 - Documentation (medical records)
 - Nature of services
 - Policies and procedures
 - Program brochures, literature

ROPI Pilot

- Purpose was to assess feasibility, utility of individual items, appropriateness, and sensitivity of anchors
 - 2 *assertive community treatment (ACT)* programs and 2 *continuing day treatment (CDT)* programs
 - Programs selected based on prior participation in a research project
 - Located in New York City, except for one ACT team in suburb of NYC

ROPI Pilot (cont'd)

Method

- 1/2 day visit
- Separate interviews with program leader and individual staff
- Reviewed 10 charts, manual on policies and procedures, and program brochures, newsletters, or other documentation
- Staff completed Recovery Self-Assessment Scale (O'Connel, et al., 2004), a 37-item self-report scale used in ROPI development process

ROPI Pilot (cont'd)

Table 1. Mean ROPI Scores by Program Type

	ACT Program 1	ACT Program 2	CDT Program 1	CDT Program 2
ROPI	4.06 (1.43)	3.24 (1.56)	3.69 (1.40)	2.44 (1.26)

Note: ROPI = Recovery-Oriented Practices Index; standard deviations are in parentheses.

ROPI Pilot (cont'd)

Table 2. Comparison of ROPI Scores and Recovery Self-Assessment Scale

Variable	ACT Program 1	ACT Program 2	CDT Program 1	CDT Program 2
ROPI (<i>mean</i>)	4.06 (1.43)	3.24 (1.56)	3.69 (1.40)	2.44 (1.26)
Rank Order ROPI	1	3	2	4
RSAS (<i>xbar</i>)	4.21 (.99)	4.01 (1.08)	3.88 (1.07)	3.44 (.92)
Rank Order RSAS	1	2	3	4

Implications and Next Steps

- Initial results suggest that recovery can be defined and measured at an organization level
- Construct validity was provisionally supported through comparisons with RSAS
- Further refinement of instrument content and anchors
- Critical step: predictive validity
 - Do more recovery-oriented programs achieve better outcomes for the clients they serve?

Implications and Next Steps

Potential Applications

- *Research & Evaluation:*
 - Can be layered on to existing fidelity scales for evidence-based practices
 - Currently in use as an evaluation tool for new licensed program type in New York State (Personalized Recovery-Oriented Services; PROS)
- *Policy:*
 - Monitoring tool for licensing or accrediting agencies
- *Clinical Intervention:*
 - Development of an intervention to promote key principles
 - Randomized trial

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