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Evaluating mental health services to promote recovery-oriented practice: A literature review; and, Resident perceptions on recovery-orientation at a supported residential unit for people with severe mental illness

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Evaluating Mental Health Services to Promote Recovery-Oriented Practice: A Literature Review.

Resident Perceptions on Recovery-Orientation at a Supported Residential Unit for People with Severe Mental Illness.

Lydia Forbes

A Report Submitted in Partial Fulfilment of the Requirements of the Award of Bachelor of Science (Occupational Therapy) (Honours) Faculty of Computing, Health and Science, Edith Cowan University.

Submitted December 2009

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Evaluating Mental Health Services to Promote Recovery-Oriented Practice: A Literature Review.

Lydia Forbes
Evaluating Mental Health Services to Promote Recovery-Oriented Practice: A Literature Review.

Abstract

Topic
A literature review was conducted to describe and critically examine the research evidence for evaluating the recovery-orientation of mental health services.

Purpose
Evaluating recovery-orientation within mental health services is a critical part of quality improvement, and the eventual widespread adoption of recovery-oriented practice. This review aimed to recommend future directions for research, highlight positive changes resulting from recovery-focused evaluation, and facilitate more effective, consumer-driven evaluation in the future.

Sources Used
Electronic databases CINAHL, PsycInfo, Medline and Meditext were searched. Articles were restricted to the English language, and included if they discussed the evaluation or exploration of recovery-oriented practices within one or more mental health services. All research methodologies were considered.

Conclusions
A narrative review was possible. Recovery-orientation was evaluated using qualitative and quantitative methodologies. Contrary to recovery principles, a general lack of consumer input was noted. Practitioners tended to rate services higher than consumers, and practitioner knowledge and attitudes around recovery varied. A large portion of research involved the development or use of recovery-orientation assessment tools, most of which required further empirical validation. Overall, methodological rigour was poor, and results were vulnerable to numerous sources of bias. Evidence was limited to level III and IV. However, if mental health services are to become recovery-oriented in an evidence-based manner, conventional ideas around the relative strength of research must be challenged. Evaluation is a catalyst for change, and should be undertaken in a consumer-driven, rigorous and recovery-focused manner for widespread change to be possible.

Key Words: recovery-orientation, mental health services, consumer evaluation, evidence-based practice.

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Submitted: December 2009
Evaluating Recovery-Orientation

Topic and Purpose

Since its emergence in the 1990s and consequent widespread acceptance, the recovery model has become the guiding paradigm across all levels of mental health service delivery (Anthony, Rogers, & Farkas, 2003; Farkas, Gagne, Anthony, & Chamberlin, 2005; Meehan, King, Beavis, & Robinson, 2008; Sowers, 2005). Mental health services are under pressure to become recovery-oriented to adhere to government guidelines (Commonwealth Department of Health and Ageing, 2008; Department of Health Western Australia, 2004; National Health Services, 2005; Trainor, Pomeroy, & Pape, 2004; U.S. Department of Health and Human Services, 2003) and best practice literature. Becoming recovery-oriented does not mean adopting a new treatment method. Rather, it requires a fundamental shift in the underlying organisational ethos and attitudes of service providers. To make a recovery-oriented mental health system a reality, real change needs to occur at every organisational level.

Evaluation enables mental health services to identify areas for change (Happell, 2008c). However, routine outcome measures in mental health have typically focussed on non-recovery related outcomes such as reduced hospitalisation, medication compliance and fewer relapses as determinants of success (Anthony et al., 2003; Happell, 2008c; Meehan et al., 2008). There is a clear need for mental health services to be evaluated in relation to recovery principles in order to facilitate quality improvement, and the eventual widespread adoption of recovery-oriented practices.

This review will describe and critically examine the research evidence for evaluating the recovery-orientation of mental health services. Examining the cumulative evidence is necessary in order to determine future directions for research, highlight positive changes resulting from recovery-focussed evaluation, and facilitate more effective, consumer-driven evaluation in the future.

Theoretical Framework

The recovery model emerged not from the traditional source of academics or professionals (Repper & Perkins, 2003). Instead, the recovery model is consumer driven, evolving from the published works of consumers about their personal
experiences of mental illness (Anthony, 1993; Peebles et al., 2007; Turner-Crowson & Wallcraft, 2002). The recovery model embodies the principle that people with mental illness can live meaningful lives beyond and despite the impact of their illness (Anthony, 1993). Although there is no universal definition of recovery, several key processes and components emerge from the literature.

Recovery is not the same as cure. Despite the presence of symptoms, relapse, or barriers posed by society, people in mental health recovery can and do lead meaningful lives (Anthony, 1993; Farhall et al., 2007). Recovery emphasises that mental illness is external to the consumer who has feelings, a history, aspirations, and innate value and worth as a human being. Discovering meaningful aspects of identity outside of being “mentally ill” is a common process in recovery (Onken, Craig, Ridgway, Ralph, & Cook, 2007). Having and upholding hope is fundamental to recovery (Andreson, Oades, & Caputi, 2003), as is social inclusion on both personal and community levels (Topor et al., 2006). Recovery is not “done to” consumers, it is a personal journey facilitated or inhibited by the surrounding physical, cultural, social and institutional environments (Davidson et al., 2005; Deegan, 1997; Mancini, 2007; Mezzina, Borg et al., 2006; Mezzina, Davidson et al., 2006). Finally, recovery is not a tangible outcome; rather it is a non-linear process which can continue for years, or a lifetime (Farhall et al., 2007).

Underpinning this review is the operationalisation of the recovery model as a recovery-orientation within mental health services. Organisations that embody recovery principles within policies and procedures, system design and evaluation, consumer involvement, staff-consumer interactions, staff knowledge and attitudes, and opportunities available to consumers are said to be recovery-oriented (Anthony, 2000). Although responsibility to recover lies with the person with mental illness, mental health services can promote and foster recovery by adopting a recovery-orientation. This review aims to critically examine and describe the literature exploring or evaluating the extent to which mental health services have adopted recovery-oriented practices.
Sources Used

Electronic database searches of CINAHL, Medline, PsycInfo and Meditext were conducted. Each database was searched from 1990 onwards, with the assumption that most relevant studies would have been published after the 1990s when the recovery model first emerged. The main search terms were: mental health services, recovery or recovery-orientation and evaluation or assessment. With the assistance of a librarian, keywords were truncated, exploded and adjusted, and subject headings modified to suit the database being searched. Reference lists of selected articles and specific journals were manually searched. A search of conference proceedings was not undertaken.

A priori criteria for inclusion of studies were applied to the abstracts. Articles were restricted to the English language. Articles were included if they discussed the evaluation or exploration of recovery-oriented practices in the context of one or more mental health services. Due to the paucity of research on this topic and the inherent difficulties in rigorously studying the concept of recovery (Anthony et al., 2003; Farkas & Anthony, 2006), this review included all levels of evidence (DePoy & Gitlin, 2005) including expert opinion, exploratory studies, and practice descriptions. This approach is consistent with the view that if mental health services are to become recovery-oriented in an evidence-based manner, conventional ideas around the relative value of research must be challenged (Anthony et al., 2003).

Methodological Considerations

Most articles included in this review were classified as level IV in the strength of evidence hierarchy, and were either expert opinion or descriptive and exploratory in nature (DePoy & Gitlin, 2005). Three studies were classified as level III (DePoy & Gitlin, 2005). Two quantitative, pre-post test designs involved the use of the Recovery Attitudes Questionnaire (RAQ) and Recovery Knowledge Inventory (RKI) to assess changes in staff knowledge and attitudes towards recovery after attending a recovery training program (Crowe, Deane, Oades, Caputi, & Morland, 2006; Peebles et al., 2009). The other study evaluated the recovery-orientation of clinical staff in a psychiatric hospital, and was classified
level III due to the use of a comparative sample of community mental health staff (Salyers, Tsai, & Stultz, 2007).

Articles reviewed included explorations, case studies, practice descriptions, and expert opinions. Several discussed tool development, pilot or validation. Three qualitative studies were the only articles to employ consumers as the sole participants, suggesting that qualitative research may be an important tool in evaluating recovery-orientation from the consumer perspective (Meehan et al., 2008). This finding raises questions about the fundamental value of quantitative assessment tools in evaluating recovery-orientation. Using mixed methods to evaluate recovery-orientation may be more useful than employing solely quantitative or qualitative methods (Anthony et al., 2003).

Due to methodological flaws, in addition to the context-specific nature of most of the studies, generalisation of many of the findings was not possible. Other qualitative or quantitative case studies and practice descriptions were not designed to be generalised (Dinniss, Roberts, Hubbard, Hounsell, & Webb, 2007b; Whitley, Harris, Fallot, & Berley, 2008).

Overall, descriptive clarity was lacking in the articles reviewed. Where some authors discussed in detail sampling procedures, the theoretical basis for tools, and general research methods, others failed to do so with clarity. In several cases where consumer perspectives were compared to those of staff, consumer participants were selected by staff themselves (Ellis & King, 2003; O'Connell, Tondora, Croog, Evans, & Davidson, 2005). This raises concerns of selection bias, whereby consumers may have been chosen purposively for their anticipated positive responses. Random sample selection was not employed in any of the studies reviewed. This may have resulted in sampling of participants who were the most motivated to participate, or those most knowledgeable about the recovery model. Social desirability, the tendency by participants to respond according to what is socially acceptable, often to frame themselves positively (Nederhof, 1985), may have influenced some results. Given the contemporary nature of recovery, self-reports of recovery-oriented practices may have been affected by social desirability, especially where staff were participants. Overall,
the general methodological rigour of the literature reviewed was poor, and researchers should aim to address these shortcomings in future research.

Discussion of Findings
A narrative review was possible with the articles included. Findings will be discussed in relation to key themes that arose from the literature: scales of consumer involvement in evaluation, recovery-orientation assessment tools, staff attitudes and knowledge, and service improvements following recovery-focussed evaluation. Research implications will be discussed throughout.

Scales of consumer involvement in evaluating recovery-orientation.
The recovery model embodies consumer empowerment, participation and choice (Anthony, 1993; Deegan, 1997; Onken et al., 2007). The subjective nature of recovery (Deegan, 1997) implies that only the service user can accurately assess the extent to which a service facilitates their recovery journey. The consumer voice is therefore central in evaluating a service’s recovery-orientation (Happell, 2008c). Power imbalances are challenged when consumers are involved in the evaluation of services (Restall & Strutt, 2008). Consumer involvement in evaluation ensures that any resulting changes are acceptable and appropriate to those accessing the service (Happell, 2008b; Klein, Rosenberg, & Rosenberg, 2007; Restall & Strutt, 2008).

Three studies were identified in which consumers were the sole evaluators of recovery-orientation. These studies employed focus group methodology to explore aspects of community and inpatient psychiatric services that promoted or hindered recovery (Happell, 2008a, 2008b; Whitley et al., 2008). Consumers described the comfort of a safe and secure base in which they could feel at ease physically, psychologically and socially. It was in these environments that individual growth and positive socialisation could occur, with many participants describing a sense of surrogate family with other service users (Whitley et al., 2008). Staff that showed respect, care, and commitment to following up with participants, and trusted participants to have input into their medication regimes, promoted recovery. Being treated as “more than a diagnosis” was important, as
was access to alternative treatments, counselling and the development of crisis management plans (Happell, 2008a).

Collectively, these studies highlighted that consumers perceive respectful social relationships with peers and staff, a safe and secure environment, and input and choice in services as adding to the recovery-orientation of services. Logically, the absence or alternatives to these aspects hindered recovery (Happell, 2008b). Participants noted that additional measures such as on-site child-care and longer opening hours would strengthen the sense of family, further promoting recovery (Whitley et al., 2008). Although the authors stated a principal purpose of the study was to inform quality improvement, there was no discussion of actions to address these suggestions (Whitley et al., 2008). These studies did not rigorously evaluate the recovery-orientation of the services involved, however their methodologies remained true to the recovery principle of empowerment through participation. If mental health services are to evaluate recovery-orientation with the intent of making real service changes, more robust methodologies are needed, ideally those utilising tools to measure recovery outcomes indicated as important by consumers (Happell, 2008a, 2008b).

Despite consumer participation being central to the recovery approach, several studies have failed to involve consumers in evaluating recovery-orientation, instead relying on the self-reported practices of staff (McVanel-Viney, Younger, Doyle, & Kirkpatrick, 2006; Ranz & Mancini, 2008). The reported recovery-oriented practices of staff included asking clients about life goals beyond symptom management (Ranz & Mancini, 2008) and advocating for clients, individually and at the service level (McVanel-Viney et al., 2006). Staff identified perceived shortcomings, such as low cultural relevance, poor consumer involvement in service planning and evaluation, and limited support for peer advocacy (McVanel-Viney et al., 2006; Ranz & Mancini, 2008). Some staff reported commitment to the recovery model, yet evidence suggested their practices were not particularly recovery-oriented (Ranz & Mancini, 2008). Without input from consumers, these results cannot be considered complete representations of the services' recovery-orientation. Furthermore,
Evaluating Recovery-Orientation recommendations offered by the authors, however legitimate, may not target the true gaps in recovery-oriented practices as identified by consumers.

In research discussing recovery-orientation assessment tools, consumer participation was evident in tool development, administration, or both. Consumers involved in tool development engaged in focus groups, surveys and web-based discussions to deconstruct and modify the tools' design (Armstrong & Steffen, 2009; Borkin et al., 2000; O'Connell et al., 2005), or participated in small-scale pilots to suggest modifications before larger-scale administration (Ellis & King, 2003). Consumers involved in tool administration formed part of the sample (Borkin et al., 2000; Casper, Oursler, Schmidt, & Gill, 2002; Dinniss, Roberts, Hubbard, Hounsell, & Webb, 2007a; Dinniss et al., 2007b; O'Connell et al., 2005) or, less often, acted as user-administrators (Dinniss et al., 2007b). More detailed discussion of recovery-orientation assessment tools will occur in the sections to follow.

Operationalising recovery in assessment tools for more rigorous evaluation.

Growing evidence has documented the development, empirical validation and application of tools designed to evaluate the recovery-orientation of mental health services. The Recovery Self Assessment (RSA) is the most prominent and well researched tool (Anthony & Ashcraft, 2005; Davidson et al., 2007; McLoughlin & Fitzpatrick, 2008; Meehan et al., 2008; O'Connell et al., 2005; Salyers et al., 2007). The RSA was developed to measure the extent to which recovery principles operate within mental health services, from consumer and stakeholder perspectives. The tool was derived from the consumer recovery literature, piloted over several years, then revised to reflect the input of mental health consumers, their families, providers and administrators (O'Connell et al., 2005). The RSA is comprised of 36 items ranked on a Likert-scale, and yields five subscales. Results of the RSA highlight areas of strength and potential growth to inform quality improvement (O'Connell et al., 2005).

Research using the RSA has highlighted several important findings related to the association between participant characteristics and recovery-oriented practices,
and commonalities across sample scores. Staff perspectives on the recovery-orientation of mental health services was associated with several professional factors. Registered nurses (n=125) rated their practices the least recovery-oriented (McLoughlin & Fitzpatrick, 2008), followed by a sample of psychiatric hospital staff (n=302), then a sample of community mental health service staff (n=182) (Salyers et al., 2007). The sample ranked the most recovery-oriented comprised of staff from 78 mental health and addictions services across Connecticut, U.S. (n=344) (O'Connell et al., 2005). Whether these 78 services were community or hospital-based was not stated. These results suggest that community mental health staff may be more recovery-oriented than clinical staff, supported by the finding that hospital staff with community mental health experience had stronger recovery-oriented practices than those without (McLoughlin & Fitzpatrick, 2008). Previous exposure to psychiatric rehabilitation or recovery principles was associated with stronger recovery-oriented practices (McLoughlin & Fitzpatrick, 2008), attesting to the positive impact of recovery-related professional development.

Studies conflicted on the association of staff age and clinical experience in relation to recovery-oriented practices (McLoughlin & Fitzpatrick, 2008; Salyers et al., 2007). Increased age and clinical experience may indicate either greater adherence to the traditional medical model or more flexibility in practice style. Future research should seek to understand the relationship between age and clinical experience and recovery-oriented practices.

For all provider groups, RSA scores were lowest on the subscale reflecting consumer involvement in service planning, development and evaluation (McLoughlin & Fitzpatrick, 2008; O'Connell et al., 2005; Salyers et al., 2007). Future studies should investigate the causes of minimal consumer involvement and seek to address these. Where consumer input was elicited, recovery-orientation was rated higher by consumers than providers (O'Connell et al., 2005). This may be due to selection bias, whereby providers may have chosen participants who were likely to rate services positively. This represents a major limitation in interpreting the results of the study, as does the absence of consumer involvement in two of the studies employing the RSA (McLoughlin &
Fitzpatrick, 2008; Salyers et al., 2007). The RSA is designed to draw upon all stakeholder perspectives in evaluating recovery-orientation and researchers should make full use of this.

Research investigating the psychometric properties of the RSA has shown the measure to have acceptable reliability and validity (McLoughlin & Fitzpatrick, 2008; O'Connell et al., 2005; Salyers et al., 2007). Internal consistency, measured by Cronbach’s alpha, has been found to range from .73 to .90 for individual subscales, and .95 to .96 for the total measure (McLoughlin & Fitzpatrick, 2008; O'Connell et al., 2005; Salyers et al., 2007). The RSA was found to have adequate stability over a two-week period (Salyers et al., 2007). Content validity has been assessed from consumer and other stakeholder perspectives (O'Connell et al., 2005). The RSA has also demonstrated acceptable convergent and discriminant validity (Salyers et al., 2007). The findings from empirical validation of the RSA support its use when evaluating the recovery-orientation of mental health services.

Several authors have utilised tools that draw upon multiple perspectives in order to arrive at a holistic representation of a service’s recovery-orientation. The Developing Recovery Enhancing Environment Measure (DREEM), a prominent recovery-orientation assessment tool (Anthony & Ashcraft, 2005; Dinniss et al., 2007a, 2007b; Shepherd, Boardman, & Slade, 2008), was used in the U.K. to ascertain which aspects of service delivery were most integral to recovery, and how a residential inpatient service rated in providing each of these. Staff (n=26) and residents (n=10) participated in the study (Dinniss et al., 2007b). The Recovery Interventions Questionnaire (RIQ) was used in Australia to determine the extent to which recovery principles operated within the case manager-consumer relationship, from the perspectives of consumers (n=15) and their case managers (n=4) (Ellis & King, 2003). Both consumer samples agreed on the importance of aspects of self-management including control, hope (Dinniss et al., 2007b), medication use, and knowing about the causes of illness (Ellis & King, 2003). A key finding of this research was the trend for staff to rate services higher than consumers. This tendency was apparent in relation to employing strengths-based practice (Dinniss et al., 2007b; Ellis & King, 2003), listening to
consumers’ concerns about medication, and increasing contact during times of crisis (Ellis & King, 2003). Staff and consumers showed significant disagreement on the service’s promotion of personal rights, social roles, addressing spiritual and sexual needs (Dinniss et al., 2007b), and the overall effectiveness of the therapeutic relationship (Ellis & King, 2003). Despite discrepancies in relation to the use of strengths-based practice, consumers recognised their skills and abilities and felt they were more able to respond effectively to a crisis than did case managers (Ellis & King, 2003).

Neither DREEM nor the RIQ have been fully psychometrically tested, and some results may be vulnerable to selection bias (Ellis & King, 2003). However, findings highlight the utility of collaborative assessment tools in exploring the recovery-orientation of services. Integrating multiple perspectives gives a holistic representation of service delivery, upon which targeted improvements can be based.

A limitation to the RSA, DREEM and RIQ is a vulnerability to socially desirable responses, inherent in self-reported data. The Recovery Promotion Fidelity Scale (RPFS) is the only recovery-orientation evaluation tool to utilise an objective, external assessor, reducing the potential for bias posed by social desirability (Armstrong & Steffen, 2009). The RPFS was developed to measure the degree to which recovery-oriented practices were implemented within public mental health services in Hawaii, U.S. (Armstrong & Steffen, 2009). Stakeholder groups, the majority of which were consumers, were involved in focus groups and concept mapping to review the tool, resulting in the 12-item RPFS. The RPFS has established face and construct validity (Armstrong & Steffen, 2009). Future studies should fully psychometrically evaluate the RPFS to determine its utility in recovery-orientation research.

_Evaluating recovery attitudes and knowledge to inform professional development._

Objectively measuring knowledge and attitudes of staff towards recovery enables training to be targeted to most effectively promote recovery-oriented practices. Several authors have developed tools to measure recovery attitudes and
knowledge of mental health services staff (Bedregal, O'Connell, & Davidson, 2006; Borkin et al., 2000; Davidson et al., 2007). The Recovery Knowledge Inventory (RKI) was developed as part of a state-wide initiative in Connecticut, U.S., to transform all mental health services to a recovery-orientation. The RKI was developed from a literature search, through consultation and subsequent revision with stakeholders, and empirical validation. The 20-item, Likert-scale tool elicits the respondent's degree of knowledge about recovery principles (Bedregal et al., 2006; Peebles et al., 2009). The Recovery Attitudes Questionnaire (RAQ) is another tool that highlights staff recovery training and education needs (Borkin et al., 2000; Crowe et al., 2006; Meehan et al., 2008). The RAQ was developed from the recovery literature then reviewed and revised by a group of consumers, mental health professionals and graduate students. Consisting of seven items ranked on a Likert-scale, the RAQ measures respondents' attitudes around different aspects of recovery (Borkin et al., 2000).

Research using the RAQ and RKI has highlighted variability in staff viewpoints in relation to recovery. Staff asserted that consumers required professional help to recover (Borkin et al., 2000), yet understood that consumers bear much responsibility in the process (Davidson et al., 2007). Uncertainty was expressed about what consumers could do outside of formal treatment to advance their recovery, but the role of peers (Davidson et al., 2007), self-definition, choice (Bedregal et al., 2006) and faith were acknowledged (Borkin et al., 2000). Staff were less knowledgeable about the complex, non-linear nature of recovery, and the expectations they should hold for consumers at different stages of their journey (Bedregal et al., 2006). They had little awareness that consumers could live meaningful lives despite the presence of psychiatric symptoms (Bedregal et al., 2006), with some staff believing that achieving recovery actually precluded the existence of mental illness (Borkin et al., 2000). Research using the RAQ and RKI has also shown that mental health staff attitudes and knowledge around recovery can improve as a result of training (Crowe et al., 2006; Peebles et al., 2009).

In addition to the RKI and the RAQ, two other tools aimed at measuring the knowledge and attitudes of mental health services staff related to recovery were
found (Casper et al., 2002; Song, 2007). These tools are preliminary and were not cited elsewhere in the literature reviewed. It is clear how the provision of targeted recovery training, using established tools to assess need, may strengthen recovery-oriented practices in staff. Future research should explore the long-term impact of recovery training on staff practices, and the subsequent relationship with consumer-reported recovery.

**Systems transformation through evaluation.**
The importance of evaluating recovery-orientation as a means of informing service development is evidenced in the literature. In Ontario, Canada, a Participatory Action Research project employed focus groups with consumers, agency staff and directors to arrive at concrete, recovery-enhancing practice modifications acceptable to all stakeholders (Jacobson et al., 2005). These modifications included the implementation of a weekly peer support group, and a consumer-run Wellness Recovery Action Plan (WRAP) program, which drew upon individual strengths and self-knowledge to empower consumers to manage daily challenges and symptom triggers (Copeland, 2002). Following its implementation, consumers trained in WRAP have assisted other mental health services to adopt the program (Jacobson et al., 2005). Other service-level, recovery-enhancing changes resulting from evaluation included implementing routine physical health screens, the development and circulation of information packages, and review of advocacy and chaplaincy services (Dinniss et al., 2007b). Recommendations to strengthen recovery-orientation included staff recovery training programs and workshops, committing to recovery-oriented practices within policies and procedures, identifying recovery competency expectations for staff, reviewing crisis contexts for non-violence (McVanel-Viney et al., 2006) and creating advance directives to reduce involuntary authoritarian treatments (Ranz & Mancini, 2008). Researchers have also suggested increasing collaboration between community and hospital-based staff as a strategy to encourage “cross-training” of recovery-oriented practices (McLoughlin & Fitzpatrick, 2008, p. 1062). Researchers have recommended using quantitative assessments for quality improvement (O'Connell et al., 2005) and including consumer and significant other perspectives in assessing recovery-orientation (Salyers et al., 2007).
Evaluating Recovery-Orientation

A major shift towards recovery-orientation was evident in the ongoing transformation of the state of Connecticut, U.S. (Davidson et al., 2007). A key step in this transformation was the operationalisation of recovery principles into defined, program-level components, which informed the development of the RSA and the RKI (Bedregal et al., 2006; Davidson et al., 2007; O’Connell et al., 2005). These tools were integral in initiating dialogue with mental health service providers to identify specific actions by which a stronger recovery-orientation could be achieved. One action included the opening of a Recovery Education and Training Institute, the curriculum of which was informed by state-wide data collected using the RKI. The Institute has offered free recovery training and technical assistance to mental health services applying to become Centres of Excellence in Recovery-Oriented Practice (Davidson et al., 2007). The transformation of Connecticut’s mental health and addictions system to a recovery-orientation has been dependent on ongoing, meaningful collaboration with stakeholders, and a dedication to making real change at the program level. The use of consumer-driven, recovery-focussed evaluation ensured that these changes were acceptable and appropriate to the consumers accessing services.

Conclusions

This narrative review has presented a critical examination of the research evidence for exploring and evaluating recovery-orientation within mental health services. The evidence has shown how recovery-focussed, consumer-driven evaluation can inform service or system-level improvements that are acceptable to consumers and stakeholders. Future research must focus on improving methodological quality and reducing bias, utilising mixed methods, drawing upon multiple stakeholder perspectives, and empirically validating preliminary tools. Researchers must seek to understand the basis for discrepancies in stakeholder viewpoints and the relationship between personal characteristics and recovery-oriented practices. Such understanding is necessary in order for real change to be possible.

In today’s era of evidence-based practice, mental health services are expected to base programming upon empirically supported research (Anthony et al., 2003; Farkas et al., 2005). As this review has demonstrated, the evidence base for
evaluating recovery-orientation is still in its infancy. While researchers strive to strengthen the evidence base, mental health service evaluations should be shaped by the best available evidence, instead of relying upon traditional hierarchies (Anthony et al., 2003).

Evaluation is a catalyst for change. Achieving the vision of widespread recovery-oriented mental health systems entails making significant changes at every organisational level. Consumer-driven, recovery-focussed evaluation may be part of the catalyst required to achieve change of this magnitude. Consumers must be supported to recover and live meaningful lives, beyond and despite the impact of mental illness, and mental health services should play their part in ensuring that this occurs.
References


Appendix

Guidelines for Authors: Psychiatric Rehabilitation Journal

**Guidelines for Authors**

**Alms and Policies**

Psychiatric Rehabilitation Journal is a peer-reviewed interdisciplinary journal published quarterly by the Center for Psychiatric Rehabilitation, Teachers College of Health and Rehabilitation Sciences, Boston University in collaboration with the US Psychiatric Rehabilitation Association (USPRA).

The purpose of the PRJ is to encourage the communication of information relevant to the rehabilitation of people with psychiatric disabilities and to promote the USPRA goal of improving the quality of services designed to support positive community adjustment and integration. To that end, the PRJ gives priority to submissions that are clearly applicable to the development, administration and delivery of services. Articles include descriptive or exploratory studies; qualitative studies; pre-post evaluations of services; measurement development or testing; survey research; and quasi-experimental or randomized studies. Literature reviews and policy studies are also accepted for review.

The journal is intended for, and encourages the submission of manuscripts from all persons involved in psychiatric rehabilitation, including consumers, family members, and mental health and rehabilitation professionals. Brief reports and book reviews are also published. Authors are encouraged to review and use the USPRA Guidelines in article submissions.

Manuscripts are initially reviewed by the editors and then sent to members of the editorial board. Manuscripts are acknowledged upon receipt. Generally, it takes 2 to 3 months between acknowledgment of receipt and notification of disposition of a manuscript. Each author receives an individual copy of the PRJ upon publication.

**Manuscript Requirements**

Manuscripts not conforming to the following guidelines will be returned to the author without review.

**Length/Word Counts.** The PRJ reviews material for publication on condition that it has not been previously published, including electronic publication, and is not being reviewed for publication elsewhere. All manuscripts submitted as articles should not exceed 5,000 words; brief reports should not exceed 1500 words; and letters to the editor should be under 200 words. Word count includes references and tables.

**Abstracts and Section Headings.** All research manuscripts should include a structured abstract after the title page with the following information, under the headings indicated:

- **Objectives:** the primary purpose of the article;
- **Methods:** data sources, subjects, design, measurement, data analysis;
- **Results:** key findings; and
- **Conclusions:** implications, future directions.

These headings should also be used to format the article text. Article abstracts should not exceed 250 words. For brief reports, the limit is 150 words.

All theoretical manuscripts should include a structured abstract after the title page with the following information, under the headings indicated:

- **Purpose:** thesis or organizing construct and the scope of the article;
- **Sources used:** personal observation, published literature, etc.; and
- **Conclusions:** implications, future directions.

These headings should also be used to format the article text.

**Key Words.** Four (4) key words must be provided for both the print and online versions of the journal.

**Biographical Information.** Limited biographical information should include the degrees, titles, and affiliations for each author in two to three lines of text.

**APA Style.** All manuscripts and references must conform to the style set forth in the Publication Manual (5th ed.) of the American Psychological Association (http://www.apastyle.org/) also known as APA style. APA style is an editorial style that consists of rules or guidelines that the PRJ observes to ensure clear and consistent presentation of written material. APA style dictates uniform use of such elements as:

- selection of headings,
- construction of tables,
- citation of references,
- presentation of statistics, and
- punctuation and abbreviations.

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Appendix

Guidelines for Authors: Psychiatric Rehabilitation Journal (cont’d)

Final Preparation. All manuscripts should be prepared for blind (masked) review (i.e., with title page free of author(s) name(s), and text free of obvious author-identifying references). Please supply with "track changes" and comments deleted. The entire manuscript, including quotations, footnotes, references, and tables, must be double-spaced. Use 12 point Times New Roman font with consistent headings and subheadings. Place all footnotes in the references at the end of the document. Tables and figures (graphs, illustrations, and line drawings) should be prepared without color and ready for production (See APA manual regarding the use, preparation, and reproduction of tables and figures). The Psychiatric Rehabilitation Journal reserves the right to change copy to conform to APA style.

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Resident Perceptions on Recovery-Orientaion at a Supported Residential Unit for People with Severe Mental Illness.

Lydia Forbes
Resident Perceptions on Recovery-Orientation at a Supported Residential Unit for People with Severe Mental Illness.

Abstract

Objective
This study aimed to evaluate the recovery-orientation of a brand new Community Supported Residential Unit (CSRU) for people with mental illness, from the residents’ perspective. Findings would inform quality improvement, and ultimately facilitate strengthened recovery-oriented practice at the CSRU.

Methods
This exploratory study used a mixed methods design, employing both qualitative and quantitative data collection methods. A sequential design was used, meaning quantitative survey data informed the collection of qualitative interview data. This design facilitated meeting the demand for quantitative outcomes in mental health research, yet allowed for contextual elaboration.

Results
Surveys showed neutral to moderate agreement that the CSRU was recovery-oriented. Participants perceived a strong recovery-orientation in the inviting layout, and weaker recovery-orientation in the diversity of services. Interviews revealed highly diverse perspectives. Respondents suggested the environment permitted the enactment of valued roles, and innately opposed discrimination. Areas for improvement included service individualisation and tailoring, broadening perceptions of the staff role, and empowering residents with information about recovery.

Conclusions
Recommendations include the negotiation of aspects of services such as house rules, and increasing awareness of resident needs, preferences, and developmental stage before admission to facilitate individualisation. An induction package is recommended to enhance resident clarity in expectations, perceptions of the staff role, and recovery. Hiring peer support workers is recommended to further empower residents around recovery, and continued recovery-based professional development for staff is suggested. Other mental health services should follow the lead of this organisation, to promote systems transformation to recovery-orientation.

Key Words: recovery-orientation, mental health services, consumer evaluation, mixed methods.

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Submitted: December 2009
Evaluating Recovery-Orientation

Objective

In Australia, the percentage of people reporting long-term mental illness rose from 5.9% in 1995, to 11% in the 2004-05 National Health Survey (Australian Bureau of Statistics, 2006). The growing number of people who experience mental illness has drawn attention to mental health providers and the services they offer. Consumers have become more vocal about their needs, and perceptions of the current state of the mental health system (Corrigan & Ralph, 2005; Deegan, 1997, 2007). The 1990s in particular were characterised by the emergence of a new approach to mental health: the recovery model, a paradigm emphasising that people with mental illness can live meaningful lives beyond, and despite, the impact of their illness (Anthony, 1993). With the support of government guidelines and best practice literature, the recovery model is now the guiding paradigm for service delivery across all levels of mental health care (Meehan, King, Beavis, & Robinson, 2008).

Mental health services can promote the recovery of service users by adopting a recovery-orientation. This does not mean simply adopting a new treatment method. Rather, it implies a fundamental shift in practitioner attitudes, and a commitment to recovery in the organisational ethos (Sowers, 2005). Recovery principles must be embedded within policies and procedures, system design, implementation and evaluation processes, and in staff competencies (Farkas, Gagne, Anthony, & Chamberlin, 2005). They must also be evident in the degree of consumer involvement, staff-consumer interactions, and opportunities available to consumers (Anthony, 2000; Farkas et al., 2005; Sowers, 2005). The recovery model is incompatible with traditional models of mental health service delivery, and as such, transforming systems of care to a recovery-orientation is a complex and challenging task (Clossey & Rowlett, 2008; Sowers, 2005). In order to make this task more manageable, specific strategies to highlight areas for change are needed.

Recovery-focused evaluation may be part of the catalyst required to direct progression towards more recovery-oriented mental health services. Despite the potential for recovery-focused evaluation to affect positive change (Davidson et
The literature on recovery-orientation is limited, with a clear need for more research. Research methods to evaluate recovery-orientation vary across the literature, suggesting there is no accepted means of measuring this elusive concept. Despite consumer participation being central to the recovery approach, there are few studies with consumers as the sole evaluators of recovery-orientation. Whilst the perspective of staff and administrators on a service’s recovery-orientation is important, it has been given preference in some of the literature (McVanel-Viney, Younger, Doyle, & Kirkpatrick, 2006; Ranz & Mancini, 2008). The few studies with consumers as the sole evaluators of recovery-orientation employed focus group methodology (Happell, 2008a, 2008b; Whitley, Harris, Fallot, & Berley, 2008), suggesting that qualitative methods may be important in obtaining the consumer perspective. This appears logical considering the complex, personal nature of recovery (Deegan, 1997). However, the demand for quantifiable outcomes in mental health services evaluation challenges the feasibility of this suggestion. Using mixed methods to evaluate recovery-orientation may be more practical than employing solely quantitative or qualitative methods (Anthony, Rogers, & Farkas, 2003).

Other researchers have evaluated recovery-orientation using quantitative, recovery-orientation assessment tools. Tools assessing the recovery attitudes and knowledge of staff, such as the Recovery Knowledge Inventory (RKI) (Bedregal, O’Connell, & Davidson, 2006) and the Recovery Attitudes Questionnaire (RAQ) (Borkin et al., 2000), have proven useful in determining training and professional development needs. Tools operationalising recovery-orientation into measurable components, such as the Recovery Self Assessment (RSA) (Davidson et al., 2007; O’Connell, Tondora, Croog, Evans, & Davidson, 2005) and the Developing Recovery Enhancing Environments Measure (DREEM) (Dinniss, Roberts, Hubbard, Hounsell, & Webb, 2007a, 2007b), have been used in different contexts to highlight strengths and weaknesses in recovery-oriented practice. The RSA is the most prominent recovery-orientation assessment tool in the literature, with studies detailing its use in community, hospital and state-wide contexts, drawing from different stakeholder perspectives (McLoughlin &
Fitzpatrick, 2008; O'Connell et al., 2005; Salyers, Tsai, & Stultz, 2007). The utility of the RSA is clearly demonstrated in the literature (Anthony & Ashcraft, 2005; Davidson et al., 2007; Meehan et al., 2008). However, it has not yet been used in an Australian study, or in a supported accommodation setting.

**Purpose of Present Study**

With the intent of beginning to address some of the gaps in the recovery-orientation evaluation literature, the present case study aimed to evaluate the recovery-orientation of a Community Supported Residential Unit (CSRU) in Perth, Western Australia. The primary purpose of the study was to inform the progression of the CSRU further towards a recovery-orientation. By doing so, the CSRU residents would be better supported in their journey towards recovery.

**Methods**

This exploratory case study was conducted using a mixed methods design, a methodology characterised by the use of both qualitative and quantitative data collection methods in a single study (Creswell, 2003). Mixed methods facilitates complementarity, whereby methods build upon one another in order to elaborate and deepen findings (Johnson, Onwuegbunzie, & Turner, 2007). The need for robust methodologies in mental health research, and the complex, subjective nature of recovery called for a unique research approach. Utilising an established, quantitative survey to contribute to scientific rigour, supplemented by qualitative interviews to facilitate contextual elaboration was deemed appropriate. As depicted in Figure 1, the collection of quantitative data informed the subsequent collection of qualitative data, a process termed sequential mixed methods (Creswell, 2003). As such, methods and results will be presented in chronological order, and then data will be integrated in the subsequent conclusions.

The recovery model served as the theoretical framework for this study, underlying data collection and analysis. At all stages, this study aligned with recovery principles of consumer participation, valuing the consumer voice, and empowerment. Approval for this study was granted by the Human Research Ethics Committee at Edith Cowan University, Western Australia.
Sample
The sample for this study was recruited from a Community Supported Residential Unit (CSRU) in Perth, Western Australia. The CSRU, the first of four long-term mental health accommodation services operated by a local charitable organisation, opened in December 2008 and has a commitment to the recovery model of service delivery. The CSRU aims to facilitate skill development and independent living for people with severe and persistent mental illness, through the provision of purpose-built, single and shared units. Support workers are on site 24 hours a day to provide residents with individualised, practical support.

Eighteen CSRU residents formed a convenience sample (DePoy & Gitlin, 2005) for the quantitative component of this study, and gave their informed consent to participate. Of those residents indicating their willingness to be interviewed, four were purposively selected for a subsequent interview. Given the limited research timeframe, four participants were deemed an achievable number. However, this meant saturation was not achieved (DePoy & Gitlin, 2005). Residents were eligible to participate if they had lived at the CSRU for more than two weeks, and received daily support from staff. They also required the cognitive capacities to complete a survey, and the verbal capacities to participate in a one-on-one interview, if applicable. Residents were excluded from the study if they had an unstable psychological status, evidenced by a recent discharge from hospital or signs of becoming unwell.

The researcher was employed as a support worker at the CSRU before and during the study. This had potential to limit participants’ open engagement in the research process. However, throughout the study it became evident that the prior establishment of trust and rapport with residents encouraged their participation and honest engagement.

Data Collection
Quantitative data was collected using the consumer version of the Recovery Self Assessment – Revised (RSA-R) (O’Connell et al., 2005). The RSA-R was developed to measure the extent to which recovery principles operate within
mental health services, from consumer and other stakeholder perspectives. The tool highlights areas of strength and potential growth to guide the development of a service’s recovery-orientation. The RSA-R has 32-items comprising six subscales: life goals, involvement, diversity of treatment options, choice, individually tailored services, and inviting factor. The items are ranked on a five-point Likert scale, with higher numbers reflecting a positive response. Research investigating the psychometric properties of the measure has shown it to have acceptable reliability and validity (McLoughlin & Fitzpatrick, 2008; O'Connell et al., 2005; Salyers et al., 2007).

Qualitative data was collected using semi-structured interviews (DePoy & Gitlin, 2005). Open and closed-ended questions were constructed to expand upon outlying RSA-R responses. Participants were guided during the interviews to explore experiences and perceptions behind their survey responses, to complement the initial RSA-R findings and add depth and contextual explanations to the data as a whole (Mortenson & Oliffe, 2009). Interviews ranged from thirty minutes to an hour and a half in length, were audio taped with permission from participants, then summarised in one page immediately after leaving the interview (DePoy & Gitlin, 2005).

Completed surveys were de-identified and stored with all other paperwork in a locked cabinet. Audio files and electronic interview transcripts were password protected on the researcher’s computer. Participants were given a gift voucher for $20, redeemable at the local shopping centre, to acknowledge their time and expertise.

Data Analysis
Descriptive statistical data analysis was used to organise and examine quantitative data, using SPSS 17.0. SPSS syntax allowed for no more than half of subscale responses to be missing to be included in analysis.

Interviews were transcribed, and then coded for meaningful data relating to the research question. Codes were then categorised according to the ten principles of a recovery-oriented service, outlined by O’Connell et al. (2005). These principles
describe a recovery-oriented service as: encouraging individualisation; fighting discrimination and promoting accurate portrayals of people with mental illness; using strengths-based practice; using a language of hope and possibility; offering a variety of options for treatment, rehabilitation, and support; supporting risk-taking, even if failure is possible; actively involving consumers, family and other supports in service development and implementation; encouraging user participation in advocacy activities; helping develop connections with communities; and helping people develop valued social roles, hobbies and interests, as well as other meaningful activities (O'Connell et al., 2005, p. 379).

Qualitative analysis was strengthened through the process of peer debriefing with an academic supervisor, who is experienced in recovery-oriented practice and qualitative research methods. Final member checking with two respondents further strengthened trustworthiness (DePoy & Gitlin, 2005).

The ten principles above were considered during the development of the RSA-R. This connection between quantitative and qualitative data facilitated comparison between, and integration of, data sets. A key component of mixed methods research is the effective integration of numeric and textual data (Creswell, 2003).

Results
Of the eighteen participants who gave their informed consent to participate, three withdrew from the study, and one who completed the RSA-R was later deemed ineligible. A total of fourteen participants comprised the final quantitative sample. Ten were male, and four were female. Ages ranged from early 20s to mid 60s. The qualitative sample consisted of four residents, with genders equally distributed. Ages ranged from late 20s to mid 60s.

Quantitative Findings
Table 1 illustrates the RSA-R subscale means and total mean for the quantitative sample. The total mean score of 3.64 indicates neutral to moderate agreement on the part of the participants that the CSRU adhered to recovery-oriented principles.
The subscale scoring the highest, 4.43, was "Inviting Factor". This reflects moderate to strong agreement by participants that the CSRU environment was warm, welcoming and inviting. The next highest score was 4.06, for the subscale of "Choice". This reflects moderate agreement by participants that residents were able to make choices impacting on their lives at the CSRU, and have their decisions about their support and care respected by staff. Neutral to moderate agreement was evident for the subscales of "Individually Tailored Services", "Life Goals", and "Involvement", with scores of 3.81, 3.71, and 3.38, respectively. Participants felt neutral to moderate agreement that they were offered services appropriate to their individual preferences, interests and skills; were supported to achieve valued life goals beyond symptom management; and were involved in service evaluation, development and implementation. The lowest score, 3.03, related to the subscale of "Treatment Diversity". This reflects neutrality from participants that they were offered a variety of options for rehabilitation and support.

Participants could also select "Don't Know" or "Not Applicable" for survey items. For item 4, "I can change my key support worker if I want to", six (42.9%) participants responded with "Don't Know". For item 5, "I can easily access my case notes and file", five (35.7%) participants indicated "Don't Know". These results suggest a lack of clarity for some participants around these issues. Five participants (35.7%) indicated strong disagreement that they felt able to discuss sexual needs with staff. Four participants (28.6%) indicated moderate disagreement that they felt able to discuss spiritual needs with staff.

**Qualitative Findings**

Qualitative findings were categorised according to the ten principles of a recovery-oriented service (O'Connell et al., 2005). Major findings are presented according to these principles. To protect anonymity, all participants are referred to as male, and other identifying data has been removed. Pseudonyms have not been used to further ensure anonymity is maintained.
**Principle 1: Encouraging individualisation.**

A recovery-oriented service encourages individualisation, both in tailoring services, and acknowledging personal preferences and values (O'Connell et al., 2005). Participant responses reflected mixed opinions on this principle. Some respondents indicated that individual needs and expectations had sometimes not been met. Some cited the "house rules" as being too restrictive. Their application to residents without tailoring to individual needs and capabilities may not align with the principle of encouraging individuality. In order to monitor residents' whereabouts and to effectively manage risk, residents were asked to check in and out with staff whenever they left or returned to the site. One respondent expressed concern that this rule was too restrictive for some:

*I think the young ones must find it hard .... I know that if I was their age, and all those rules applied, I wouldn't stay.*

Taking of medications was also monitored daily by staff. One respondent cited this as intrusive, expressing frustration that his long-standing independence managing medication was not acknowledged:

*All this checking the medication drives me crazy .... I've always managed my own medication. I mean I've been doing it for years.*

One respondent indicated that an expectation of safety and protection was unmet, evidenced by his often feeling unsafe. Frustrations at the unmet need for attention to physical problems were also expressed. Individual values, such as the importance of living alone, were sometimes unaddressed. One respondent, who had lived alone for many years, lamented that he now lived in shared accommodation:

*I just hope one day that I'll find a unit of my own. Then I think it'll feel more like a home. If I was by myself.*

On the contrary, acknowledgement of other individual preferences and values
illustrated a degree of individualisation in service delivery. Several respondents described the environment of the CSRU as allowing them to enact the value of "feeling like home", with freedom to decorate their units with personal and meaningful items. Individual preferences such as being "left alone" with the freedom to carry out longstanding routines, and undertake meaningful activities, were acknowledged in service delivery:

The house is the most important place to me ... and keeping it clean and tidy.

The staff are really good. They don't intrude in my life.

I can always find something to do .... I've got enough things to do in my own life, things, little goals I set.

For these respondents, the freedom afforded by the CSRU to fulfil individual needs was important.

Principle 2: Fighting discrimination, promoting accurate portrayals of people with mental illness.
A recovery-oriented service aims to fight discrimination and promote accurate depictions of mental illness within all aspects of service delivery (O'Connell et al., 2005). Respondents gave several examples to indicate that the CSRU was achieving this aim.

One respondent described how he was treated as "normal" by staff, indicating that staff viewed residents as more than an illness, acknowledging their personhood. His expression of gratitude for this treatment suggested he was perhaps used to being treated as other than "normal":

Yeah, everyone treats me fairly well, as if I'm an equal, and I'm normal, and all that. Even though I'm taking medication – I'm not normal. I have a mental illness .... I'm just grateful for the way people treat me, because they treat me ... as if I was completely [participant name], myself.
The physical environment of the CSRU was described as inviting, comfortable, tidy, and well laid-out. The residential complex appeared like any other in the area. The “normalcy” of the CSRU may promote a positive view of mental illness, emphasising that people with mental illness can and do live like anyone else.

Principle 3: Strengths-based practice.
Strengths-based practice is an integral component of a recovery-oriented service (Clossey & Rowlett, 2008; O’Connell et al., 2005; Shepherd, Boardman, & Slade, 2008). Interview responses suggested that several residents could have been better assisted to build strengths required to progress in their recovery.

In order to be empowered to begin to recover, people need to be able to access accurate information around recovery, and be supported to understand and apply it to their lives. Respondents had differing views on recovery, most of which were opposed to the idea of recovery as a process, or journey. Recovery was often seen as dependent on cure, or a rare occurrence:

*The only way I see that I would recover is if I’m like 32 years old, and my illness goes away...*

*You have to be really blessed to have that.*

Respondents expressed a lack of certainty around what staff knew of their personal strengths and skills, especially around self-management of symptoms. One respondent described numerous activities and tools he previously used to control his symptoms, in addition to taking his medication. However, he felt that since moving to the CSRU he had used these self-management skills much less, due to barriers described as low motivation and constraints posed by colder weather. One respondent described an instance where a staff member carried out a task for him, whereas he expressed in the interview that he was capable of completing the task himself. These examples highlight how staff may have missed opportunities to capitalise upon residents’ skills and abilities.
Principle 4: Using a language of hope and possibility.

Recovery-oriented services embody hope and possibility, in order to inspire hopefulness and belief amongst service users for their recovery (Farkas et al., 2005; O'Connell et al., 2005; Torrey & Wyzik, 2000). Respondents’ expectations of life at the CSRU illustrated how the environment inspired hope and optimism for their future. The importance of permanence, and a secure home for years to come was evident amongst respondents, illustrating a degree of optimistic, forward thinking:

[I expected] that it's a nice place to stay ... That I'd have the opportunity to stay somewhere safe, and I wouldn't have to go to the hospital all the time. I'd have a permanent place to live if I wanted to stay here for a long period of time.

Counter to this principle, one respondent described how staff could sometimes be “strict” in their ensuring medication compliance. However, staff were described as nice and approachable at other times, with residents’ wellbeing in mind, and encouraging of high expectations.

Principle 5: Offering a variety of options for treatment, rehabilitation, and support.

A recovery-oriented service offers a variety of options for treatment, rehabilitation and support (Anthony, 2000; O'Connell et al., 2005; Sowers, 2005). Respondent opinions varied on the strength of this principle at the CSRU.

Some respondents expressed satisfaction with their level of support, suggesting that the variety of service options suited their preferences and needs. Support included assistance to carry out activities of daily living such as cleaning, cooking and shopping, and encouragement to get a job. These respondents also indicated that the rules and regulations were acceptable to them. The responses of others suggested that services may not have been varied enough to suit individual needs and preferences. This was illustrated by the perception of the staff role as largely restricted to medication management:
Staff just wanna make sure you take your meds, you’ve been to get your needle, or your test done.

You know, staff say, “go and get your medication, go take tablets, get sleep”. And you end up sleeping all the time on medication all day, and there’s nothing you do.

One respondent also felt that there were limited activities to get involved with, and as a result characterised the days by undertaking medical duties:

They say they’re gonna teach art work and you go to do that, but there’s nothing really happening, and they say come to certain places, but nothing really happens ... and then you end up getting blood tested [at the hospital]... for your medication and you feel really lousy.

Certain activities that were offered, such as art groups or pool competitions, were unattended by some, with reasons including difficulties “mixing with others”, physical barriers to engagement, or they were simply “not for me”.

A variety of service options implies choice for service users to select the services and supports appropriate for them. Reduced choice in services was reflected by respondents’ uncertainty around the role of support workers, the allocation of key support workers and what was permitted in the house rules:

Who is my key support worker?

I think one of the requirements of being here is that you’re on medication, you know? (House rule: Residents are expected to be independent in medication management)

I sort of thought the rules were you don’t want to drink at all. (House rule: Alcohol is not allowed on the premises)
A recurring theme was the lack of awareness around access to personal case notes and other documents. Some respondents were unaware that they could choose to see their file, and they had the right to do so. However, several respondents, although initially being unaware that they had the choice to access their file, felt comfortable approaching staff to do this.

**Principle 6: Encouraging risk-taking, even if failure is possible.**
A recovery-oriented service should encourage risk-taking in service users, even if failure is possible (O'Connell et al., 2005; Torrey & Wyzik, 2000). This promotes individuality, pride, skill development and identity definition outside of being “mentally ill”. Data on this principle was minimal in the interviews, except for a discussion around ceasing medication:

*If I said I wasn’t going to take my [medication] anymore, cos I don’t want it, cos it [causes uncomfortable side effect], then they would ... they wouldn’t really like that, you know?*

This respondent suggested that he felt limited choice and support from staff to “risk” changing or ceasing his medication.

**Principle 7: Considering the input of consumers, family, and other significant supports in service and program development and implementation.**
A recovery-oriented service considers the input of all stakeholders, including consumers and family members, when developing and implementing programs (Anthony, 2000; Farkas et al., 2005; O'Connell et al., 2005; Sowers, 2005). Those most affected by a service must be able to shape its development (Happell, 2008c). Respondents had varying opinions on the strength of this principle at the CSRU.

Family involvement in service delivery was very important and influential for one respondent, with the supervisor regularly keeping in touch with his significant others and valuing their input. Another respondent reportedly had a large support network, yet this network had little connection with the CSRU environment.
One respondent described the anxiety he felt when a particular support worker he felt close to stopped working at the CSRU, suggesting that this respondent may not have been informed of, or prepared for, the implications of staff turnover. Several respondents described a tendency to keep their thoughts and feelings to themselves, and not voice their concerns:

\[ I \text{ have a habit of always saying I'm good ... and lots of times I'm not.}\]

This has implications for involving residents in service development and evaluation.

\textit{Principle 8: Encouraging involvement in advocacy activities.}

Service users should be encouraged to get involved in advocacy activities in order to facilitate skill development, build confidence, and secure rights and freedoms (Anthony, 2000; O'Connell et al., 2005). Respondents gave several examples of how the CSRU could improve in this area.

Several respondents expressed frustration with personal issues they faced as a result of their medication. These included various physical side effects, and a feeling of being “brushed aside” by doctors when discussing changes to medication regimes. One respondent’s perceived lack of control over these issues suggested a need for advocacy:

\[ I \text{ don't know what to do about it apart from see my doctor, or ask to see someone to talk about it.}\]

Another respondent described an incident where he was not given the opportunity to advocate for himself during a major change in living situation. This resulted in unresolved feelings of hurt and anger, and a missed opportunity for staff to facilitate this resident’s skills and confidence in advocating for himself.
Principle 9: Developing connections with the community.

Recovery-oriented services encourage and facilitate the development of connections with the community (O'Connell et al., 2005). The interviews did not yield sufficient data relating to this principle, except for the encouragement by staff to obtain employment, thus creating a new link within the community.

Principle 10: Assisting service-users to develop valued social roles, interests, and hobbies, as well as other meaningful activities.

A recovery-oriented service assists service users to develop valued social roles, interests and hobbies, and pursue other meaningful activities (O'Connell et al., 2005). This is to facilitate identity redefinition, build skills, create meaningful therapeutic outlets and provide daily structure.

As previously mentioned, some respondents expressed a lack of diversity in service options, such as activities. For another respondent, the art activities offered were suitable and enjoyable, yet the respondent was unaware that they were available until interviewed. One respondent lamented that he had not been supported to find work sooner, and for him, work was an important aspect of recovery.

They could have given me work from day one. Instead of saying, “I've come home, I've gone [out and done an activity]”, what about saying, “I've come home from the factory, and I've made some money”?

However, for others, the CSRU environment created an opportunity to pursue meaningful activities and fulfil valued social roles and hobbies. One respondent described being able to fulfil a caring role with other residents, sharing cooked meals and giving lifts to residents. The small community at the CSRU allowed this respondent to enact a valued role. Most respondents described a sense of satisfaction gleaned from maintaining a clean, tidy and homely unit. For one respondent, the simple act of washing dishes invoked memories of family and youth:
We wash the dishes at home where we used to live, we believed that there's work to be found, if you have a mental illness. You get well, things like that. All the qualities of cleaning up, and every day life, this is how we had it when we were kids.

For another respondent, decorating the home with crafts provided satisfaction. The home was a place where family could visit, and where residents could talk to their family on the phone. The CSRU environment facilitated the enactment of a daily, personal routine, which was very important for one respondent.

Conclusions

This study aimed to evaluate the level of recovery-orientation at a CSRU in Western Australia from the consumer perspective. All findings and associated recommendations will be circulated to the organisation's administrators to feed into the quality improvement process, and ultimately strengthen the recovery-orientation of the CSRU.

It is important to recognise that the CSRU is not just the organisation's first long-term supported accommodation mental health service. It is also the organisation's first attempt at establishing a recovery-oriented mental health service. Establishing a recovery-orientation is similar to the process of recovery in individuals; it is complex, requiring dedication, time and commitment (Sowers, 2005). The organisation is to be commended on the establishment of a long-term accommodation service that is inviting, welcoming and facilitates the enactment of highly important occupational roles (Crepeau, Cohn, & Boyt Schell, 2003). Research has attested to the positive impact of a secure and comfortable home at which to base recovery (Chesters, Fletcher, & Jones, 2005). Critical needs such as housing must be met before recovery can take place (Clossey & Rowlett, 2008; Sowers, 2005).

The perception of the role of staff as largely related to medication management was reflected in the RSA-R subscale scores for treatment diversity (3.03) and life goals (3.71). Diverse support options, and the attainment of goals beyond medication management were not likely to exist if residents perceived the staff
role to be confined in this way. This perception raises questions about residents' expectations of the CSRU. Expectations beyond support to manage medication existed, but for some were unmet, given the subscale scores above. There appeared a mismatch between the perception of the role of staff, and expectations held about what would be offered at the CSRU. To address this, it is recommended that an induction package be offered to residents at or before admission. Consumers cannot be empowered to take control of their health and make informed choices without access to understandable, accurate information (Torrey & Wyzik, 2000). The package could clearly explain the role of staff, and what residents can expect from the service. It could ensure that residents know of their right to access personal information, and that they have a key support worker on site whom they can change if desired. To encourage consumer involvement, and raise resident awareness of the commitment the organisation has to recovery, current residents could be involved in the development of the package. The implementation and impact of the package could also be the subject of future research at the CSRU.

The induction package could also empower residents with the knowledge of what recovery is, and what it may involve. To explain recovery, “model” its benefits, and provide on-going support and mentoring (Peebles et al., 2007), peer support workers may be useful in this process, and at the CSRU in general. Peer support workers have been integral in enhancing the recovery-orientation of mental health services overseas (Ashcraft & Anthony, 2005), and their contribution to recovery-oriented services is recognised in Western Australia (Department of Health Western Australia, 2004). It is recommended that organisational management consider employing peer support workers at the CSRU.

Through their involvement with mental health services, consumers build many therapeutic relationships, which can be important to recovery (Topor et al., 2006; Torrey & Wyzik, 2000). Unfortunately, staff turnover and consumer movement through the system means that these relationships are often lost. It is recommended that CSRU residents be more informed about any staffing changes. This would limit any anxiety or distress resulting from significant relationships being unexpectedly terminated. The residents could be involved in
discussion of the reasons for a staff member leaving (within the limits of privacy for the staff member), whilst determining actions to support the residents during the change.

Data from this study has suggested that the recovery-orientation of the CSRU could be enhanced through further individualisation of services. Respondents indicated that certain needs, values, and preferences for living were not acknowledged in service delivery. Awareness of, and consideration to individuality would not only facilitate tailored services, but also strengths-based practice, diversity in service options, and assistance to pursue meaningful occupations and life goals. When considering house rules, it must be recognised that the organisation is obliged by licensing requirements and internal policies to implement certain risk management measures. However, negotiating rules with each resident before admission may be a more recovery-oriented way to manage risk, whilst acknowledging individuality and encouraging consumer involvement. This negotiation process could be interwoven into the collaborative development of care plans with each resident, a procedure currently being implemented by the organisation. Having case managers and other relevant clinicians involved would make this process a powerful means for understanding individual needs and preferences, then negotiating services accordingly.

Both experiencing a mental illness, and the impact of being a service user can disrupt one’s natural progression through developmental milestones, including those related to autonomy and identity (Mandich, 2005; Schindler, 2004). As well as determining a resident’s needs and preferences, understanding their developmental factors may increase understanding of how the person might perceive, and respond to, house rules and other service implications. This would assist in negotiation. There will be situations when a resident’s personal needs and preferences cannot be met at the CSRU, for example if single occupancy units are preferred but not currently available. Being aware of, and addressing the individual’s feelings and attitude around this situation, would facilitate the negotiation of appropriate supports. These might include compensatory measures and coping skills.
All of the recommendations offered, if implemented, would be enhanced by the continual professional development of CSRU staff around personal recovery processes, strengths-based practice, developmental milestones, and tailoring services. Clinicians such as occupational therapists are in a prime position to act as trainers, with their expertise in these areas. The recovery training needs of staff could be accurately determined through future research with staff as participants, using a tool such as the Recovery Knowledge Inventory (RKI) (Bedregal et al., 2006). The importance of continued professional development and the attainment of recovery competencies in staff is well recognised (Anthony, 1993, 2000; Davidson et al., 2007; Farkas et al., 2005; Sowers, 2005).

Reflections on Mixed Methods Design
The use of mixed methods in this study proved useful not only through complementarity, whereby interviews elaborated upon RSA-R scores (Johnson et al., 2007). Findings were also strengthened through corroboration between data sets. The use of an anonymous survey gave residents freedom to give honest feedback. Interviews allowed respondents to express themselves freely without restrictions imposed by the survey. Integrating qualitative and quantitative findings proved to be difficult, even with the link between the RSA-R and the interview framework. Future research employing this methodology could use the RSA-R subscales as a broad qualitative framework, but allow for other themes to emerge inductively.

Limitations
The RSA-R scores cannot be compared to other studies because to date, the only studies using the tool have used the original RSA. Future research should use the RSA-R in various settings in order to establish a basis for comparisons. Staff and other stakeholder perspectives were not elicited in this study. Future research at the CSRU and other settings should capitalise on the flexibility of the RSA-R to capture multiple perspectives. The small number of participants limits this study’s findings, and therefore achievement of the aim. The diversity in responses across both data sets, and the fact that saturation was not reached in qualitative data, suggests widespread resident perspectives on the recovery-orientation at the CSRU. Many of these perspectives remain unheard. Future
research at this CSRU and other mental health services should explore ways of encouraging participation in order to make findings, and recommendations, as representative as possible. Since this study was context-specific, generalisation of findings was not intended; however, replication of the research methodology is possible in other settings.

**Summary**

For a mental health service to become recovery-oriented, real change needs to occur at every organisational level. The organisation involved this study has taken a step in this direction by being open to evaluation and change, and in doing so, has demonstrated commitment to the recovery model of service delivery. Other mental health services must follow this lead. In the current mental health system, the only way consumers can be best supported towards recovery is if the system itself begins to recover.
References


Evaluating Recovery-Oriented Practices


Appendix A
Figure 1 and Table 1

Figure 1. Diagram of mixed methods sequence (Creswell, 2003, p. 213).

Table 1
Minima, maxima, means and standard deviations (SD) for RSA-R total score and subscale scores for n=14 participants.

<table>
<thead>
<tr>
<th></th>
<th>Min.</th>
<th>Max.</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Goals</td>
<td>2.75</td>
<td>4.55</td>
<td>3.71 (.57)</td>
</tr>
<tr>
<td>Involvement</td>
<td>1.60</td>
<td>5.00</td>
<td>3.38 (.94)</td>
</tr>
<tr>
<td>Treatment Diversity</td>
<td>2.20</td>
<td>4.20</td>
<td>3.03 (.66)</td>
</tr>
<tr>
<td>Choice</td>
<td>2.25</td>
<td>5.00</td>
<td>4.06 (.82)</td>
</tr>
<tr>
<td>Individually Tailored Services</td>
<td>3.00</td>
<td>5.00</td>
<td>3.81 (.61)</td>
</tr>
<tr>
<td>Inviting Factor</td>
<td>3.00</td>
<td>5.00</td>
<td>4.43 (.58)</td>
</tr>
<tr>
<td>RSA-R Total</td>
<td>2.74</td>
<td>4.53</td>
<td>3.64 (.50)</td>
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Appendix B

Guidelines for Authors: Psychiatric Rehabilitation Journal

The Research Report will be submitted to the same journal as the Literature Review. Refer to page 23-24 for the Author Guidelines for this journal.