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Do clinical outcome measures assess consumer-defined recovery?

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ABSTRACT

There is an international call for mental health services to become recovery-oriented, and also to use evidence-based practices. Addressing this call requires recovery-oriented measurement of outcomes and service evaluation. Mental health consumers view recovery as leading as meaningful life, and have criticised traditional clinical measures for being too disability-oriented. This study compares three measures of consumer-defined recovery from enduring mental illness: the Recovery Assessment Scale, the Mental Health Recovery Measure and the Self-Identified Stage of Recovery, with four conventional clinical measures. Correlational analyses supported the convergent validity of the recovery measures, although certain subscales were unrelated to each other. More importantly, little relationship was found between consumer-defined recovery and the clinical measures. Analyses of variance revealed that scores on the recovery measures increased across self-identified stage of recovery, but scores on most clinical measures did not improve consistently across stage of recovery. The findings demonstrate the qualitative difference between the two types of measures, supporting the claim by consumers that clinical measures do not assess important aspects of recovery. There is a need for further research and refinement of recovery measurement, including assessment of stages of recovery, with the aim of including such measures as an adjunct in routine clinical assessment, service evaluation and research.

1. Introduction

Mental health consumers with enduring mental illnesses, such as schizophrenia and bipolar disorder, have been advocating for some time that services should be recovery-oriented, and this goal is being incorporated internationally into mental health policy, predominantly in the English speaking world (Slade et al., 2008). 'Recovery', as used by mental health consumer advocates, differs from the commonly-held meaning of the return to a previous level of health and functioning after illness. Consumer-oriented definitions of recovery refer instead to changes in attitude to life and the illness, emphasising the role of hope. They refer to the establishment of a meaningful and fulfilling life, a positive sense of identity and taking responsibility for one's own wellbeing (e.g. Anthony, 1993; Andresen et al., 2003; Resnick et al., 2005; Slade et al., 2008). Treatment approaches based on the consumer recovery model are being developed and applied worldwide. Concurrent with demands for recovery-oriented services, policies internationally are requiring evidence-based mental health services. While traditional outcome measures have tended to assess such things as symptoms, hospitalisations and functioning, and stem from medical conceptualisations of mental illness, consumers describe the experience of *psychological* recovery which can take place (a) in the presence of ongoing or recurring symptoms, (b) with choice regarding the use of medications, and (c) while choosing to access services and/or hospital treatment (Andresen et al., 2003). The recovery vision is one of attaining a productive and fulfilling life regardless of the presence of recurring symptoms (Crowley, 1997). This entails an examination of one's core self to find a foundation for building a meaningful life in a personally-valued role (Andresen et al., 2003). Measures of symptoms, medication compliance, service utilisation and skills largely exclude these intrapersonal processes of psychological recovery, and so do not reflect the consumer definition of recovery. Lakeman (2004) argues that, rather than informing recovery-oriented practice, such measures rob the lived experience of all meaning: "quantification does not make an observation more objective, 'evidenced based' or meaningful" (p. 212).

This position does not suggest that objective measures should be abandoned, but rather, that they be augmented by measures of consumer-defined recovery. A recent study demonstrated that goal attainment mediated the relationship between baseline levels of symptom distress and progress on recovery (Clarke et al., 2009). Similarly, Resnick et al. (2004) found that, although severity of symptoms was inversely related to a recovery orientation, reduction of symptoms does not automatically lead to psychological recovery. For example, Resnick et al. also found that severity of symptoms was *not* related to hope, the core of the recovery process. It is therefore important to ensure that the achievement of traditional treatment goals is in fact facilitating psychological recovery (Silverstein and Bellack, 2008). To that end, outcome measurement, evaluation studies and research should include assessment of the subjective experience of recovery, as it has been described by consumers.

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To date, there is no universally-accepted criterion for operationalising the concept of recovery. Given that recovery is represented by consumers as a unique, personal journey, there has been a reticence to define it as an outcome (Torrey et al., 2005), however, some recovery measures have been developed. Campbell-Orde et al. (2005) compiled the *Compendium of Recovery Measures*, which includes measures of individual recovery and measures of recovery-promoting environments. Measures of individual recovery can be categorised into two domains: those that focus on psychological processes of the person, and those that assess satisfaction with various life domains and treatment.

This study focuses on measures of the intrapersonal process of psychological recovery, such as hope and optimism, self-determination, resilience, positive identity and finding meaning and purpose in life. Of the measures in the Compendium only two could be considered to fit this narrow definition: the Recovery Assessment Scale (RAS; Corrigan et al., 1999) and the Mental Health Recovery Measure (MHRM; Young and Ensing, 1999; Young and Bullock, 2003). Both the RAS and the MHRM were based on consumers' descriptions of their experience of the recovery process.

In addition to the intrapersonal recovery processes, there exists a substantial literature, based on qualitative research, which describes recovery as taking place in stages or phases. For example, Davidson and Strauss (1992) identified four aspects of recovery of the sense of self in severe mental illness. These were described as: "(1) discovering the possibility of possessing a more active sense of self, (2) taking stock of strengths and weaknesses and assessing possibilities for change, (3) Putting into action some aspects of the self and integrating the results as reflecting one's actual capabilities and (4) using an enhanced sense of self to provide some refuge to provide a resource against the effects of the illness and [such things as stigma]" (Davidson and Strauss, 1992, p. 134). Although Davidson and Strauss point out that these four aspects do not necessarily occur in a linear fashion, but are related and overlapping, there is a logical order to the four aspects. Three emotional stages of recovery were described by Baxter and Diehl (1998): (1) Recuperation, a stage of dependence following crisis; (2) Rebuilding, a time of building independence, and (3) Awakening, a time of building interdependence. Three phases were also posited by Young and Ensing (1999) in a model which encompasses six aspects and numerous processes of recovery. The three phases of recovery were described as: Phase I, *Overcoming "stuckness"*; Phase II, *Regaining what was lost and moving forward*; and Phase III, *Improving quality of Life* (Young and Ensing, 1999). Spaniol et al. (2002) identified four phases of recovery in the literature: (1) Overwhelmed by the disability; (2) Struggling with the disability; (3) Living with the disability, and (4) Living beyond the disability. Spaniol et al. were able to place research participants in each of the first three phases, but not in the fourth phase. Tooth et al. (1997) and Lapsley et al. (2002) also found references to stages of recovery in large qualitative studies in Australia and New Zealand respectively.

A stage model of psychological recovery, reflecting the parallel findings of these qualitative studies has been developed (Andresen et al., 2003) (see Table 1). The model consists of a five-stage process: (1) Moratorium (withdrawal, hopelessness and a negative sense of identity), (2) Awareness (hope and an awareness of intact aspects of the self), (3) Preparation (the examination of core values and the implementation of internal and external resources), (4) Rebuilding (taking steps towards meaningful goals) and (5) Growth (living a fulfilling life and looking towards a positive future). The model also identifies four psychological processes: finding and maintaining hope, taking responsibility for one's life and wellbeing, building a positive identity and finding meaning in life. In light of the common findings of the qualitative studies, measures based on a stage model may provide a particularly useful framework for further research. Andresen et al. (2006) developed two measures based on this stage model: the 50-item Stages of Recovery Instrument and the brief Self-Identified Stage of Recovery.

The inclusion of three recovery measures: the Recovery Assessment Scale (RAS; Corrigan et al., 1999), the Mental Health Recovery Measure (MHRM; Young and Bullock, 2003), and the Self-identified Stage of Recovery (SISR; Andresen et al., 2006) with four conventional clinical measures in a large multi-site study (Oades et al., 2005) provides an opportunity to test the construct validity of recovery measurement. First, we build on preliminary work (McNaught et al., 2007) to address the questions (1) Do recovery measures demonstrate convergent validity? (2) Do recovery measures provide unique information that may supplement conventional clinical measures, and (3) Do scores on recovery measures and clinical measures improve across stage of recovery as assessed by the SISR?

2. Method

2.1. Participants

The research used baseline data from participants in the Australian Integrated Mental Health Initiative. This large, multi-site project, investigating the Collaborative Recovery Model (Oades et al., 2005), involved four government and five non-government organisations across the eastern states of Australia. Inclusion criteria for participants were that they were aged 18 years or over, had a diagnosis of a psychotic disorder of at least six months duration and had high support needs as assessed by the CANSAS (Phelan et al., 1995). Case managers recruited participants from their current case load. Individuals with cognitive deficits or brain injury which would prevent them from giving informed consent or from completing the questionnaires were excluded.

After informed consent had been given, a standard battery of instruments was administered during routine clinical sessions. The client-rated measures were completed independently, unless the client requested the assistance of the clinician or a research assistant.

Baseline data from the first 281 participants were accessed. A subset of this data, representing 110 participants, was used for Phase 1 of the study to address the first two research questions. These data were combined with an additional 171 for Phase 2, in which we investigated the third research question. The demographic data for participants in each part of the study are shown in Table 2.

Table 1
Five stages of psychological recovery, incorporating stages and phases of recovery described in four qualitative studies.

Stage of psychological recovery (Andresen et al. (2003))	Davidson and Strauss (1992)	Baxter and Diehl (1998)	Young and Ensing (1999)	Spaniol et al. (2000)
Stage 1 Moratorium		1. Crisis *Recuperation*		1. Overwhelmed by the disability
Stage 2 Awareness	1. Awareness of a more active self		I. Initiating recovery	
Stage 3 Preparation	2. Taking stock of self	2. Decision		2. Struggling with the disability
	3. Putting self into action		II. Regaining and moving forward	
Stage 4 Rebuilding	4. Appealing to the self	*Rebuilding independence*		3. Living with the disability
Stage 5 Growth		3. Awakening *building healthy interdependence*	III. Improving quality of life	4. Living beyond the disability

Adapted from Andresen, R., Oades, L. & Caputi, P. (2003) The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry (37)* 5, 586–594. With permission, Taylor & Frances Ltd, http://www.tandf.co.uk/journals.