



Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

The relationship between clinical and recovery dimensions of outcome in mental health[☆]

Rob Macpherson^{a,*}, Francesca Pesola^b, Mary Leamy^b, Victoria Bird^b, Clair Le Boutillier^b, Julie Williams^b, Mike Slade^b

^a 2gether NHS Foundation Trust, Gloucestershire, England, United Kingdom

^b King's College London, Institute of Psychiatry, Psychology & Neuroscience, London, England, United Kingdom

ARTICLE INFO

Article history:

Received 14 January 2015

Received in revised form 21 October 2015

Accepted 21 October 2015

Available online xxxxx

Keywords:

Clinical recovery

Personal recovery

ABSTRACT

Background: Little is known about the empirical relationship between clinical and personal recovery.

Aims: To examine whether there are separate constructs of clinical recovery and personal recovery dimensions of outcome, how they change over time and how they can be assessed.

Method: Standardised outcome measures were administered at baseline and one-year follow-up to participants in the REFOCUS Trial (ISRCTN02507940). An exploratory factor analysis was conducted and a confirmatory factor analysis assessed change across time.

Results: We identified three factors: patient-rated personal recovery, patient-rated clinical recovery and staff-rated clinical recovery. Only the personal recovery factor improved after one year. HHI, CANSAS-P and HoNOS were the best measures for research and practice.

Conclusions: The identification of three rather than two factors was unexpected. Our findings support the value of concurrently assessing staff and patient perceptions of outcome. Only the personal recovery factor changed over time, this desynchrony between clinical and recovery outcomes providing empirical evidence that clinical recovery and personal recovery are not the same. We did not find evidence of a trade-off between clinical recovery and personal recovery outcomes. Optimal assessment based on our data would involve assessment of hope, social disability and patient-rated unmet need.

© 2015 Published by Elsevier B.V.

1. Introduction

Recovery, defined as “a way of living a satisfying, hopeful, and contributing life even with any limitations caused by illness” (Anthony, 1993), has an increasing empirical evidence base (e.g. Law and Morrison, 2014). However, it is also clear that the term ‘recovery’ has been used in different ways. The literature contains at least four types of frameworks to understand recovery from mental health problems and these can be summarised as follows: *Clinical recovery* generally refers to clinical outcomes, professionally rated by the presence of symptoms of illness. In this context recovery refers generally to the absence of disease or cure (Torgalsboen, 2013) with schizophrenia-related disorders, and underpins epidemiological research (Austin et al., 2013). The concept of *Personal recovery* which has emerged from the consumer movement in the past 20 years has a number of characteristics which focus on outcomes important to the recovering individual and

distinguish it from more clinically based models: Recovery is individually defined, through an understanding of narrative and founded on the concept of an individual's journey of growth and personal development. This form of recovery focuses mostly on social success and individually defined forms of progress, rather than symptom control. Dealing with stigma (Deegan, 1988) and the development of self-confidence and hope (Corrigan and Watson, 2006) are critical elements of the process. Some authors (Frese et al., 2001) have noted the potential for conflict between evidence based medicine approaches and the recovery approach, given that many with the highest levels of disability often reject the evidence. The authors argue for an integrated model which recognises the need for structured support at times of greatest need, which must give way to greater autonomy as the individual's disability improves.

Internationally, mental health systems are transforming services to promote a recovery focus (Mental Health Commission of Canada, 2015). Therefore we need to develop clarity about how this approach to mental health work is measured and healthcare professionals need guidance to inform their clinical decision-making and actions (Le Boutillier et al., 2015a and Le Boutillier et al., 2015b). However, empirical research in the field of personal recovery is at an early stage of development and there is an obvious challenge in reducing an individual's

[☆] Trial information: The Refocus study (<http://www.researchintorecovery.com/refocus>) was approved by East London Research Ethics Committee (Ref. 11/LO/0083).

* Corresponding author at: Leckhampton Lodge, Charlton Lane, Cheltenham GL53 9EZ, United Kingdom.

E-mail address: rob.macpherson@glos.nhs.uk (R. Macpherson).

recovery to a set of domains for systematic analysis across groups (Slade, 2009). The unpredictability of outcomes, with or without treatment, suggests that finding simple associations between these factors may be difficult. It may be that approaches which use multiple sources to define a multi-faceted approach to defining recovery are needed and this fits with qualitative research which showed that recovery could occur in three domains (biomedical, psychological and social) and could be complete or partial (Henderson, 2010). The evidence base indicates that clinical and recovery measures assess different aspects of outcome. There is a developing literature concerned with the different concepts of recovery and many studies have analysed concepts of recovery beyond symptomatology. Law and Morrison (2014) used a Delphi approach to establish consensus about the meaning of recovery among individuals with experience of psychosis and went on to consider implications for clinical practice. Attempting to find an approach which encompasses service user, professional and political considerations, Whitley and Drake (2010) proposed five superordinate dimensions of recovery and identified lay, professional, and systemic resources that promote each dimension. The empirical analysis by Gordon et al. (2014) produced five core dimensions to the concept of recovery and these authors noted the potential value of an agreed set of dimensions for recovery, which could potentially be used to inform service provision and outcomes. Gould et al. (2013) considered the important relationship between recovery and aspects of individual goal attainment.

The aim of this study was to investigate the relationship between clinical outcomes, which relate to illness and deficit amelioration; and recovery outcomes, which relate to subjective experiences such as hope and empowerment. Objective 1 was to identify groupings of outcome domains. Objective 2 explored how the identified groupings change over time. Objective 3 was to identify the most informative standardised measure for each grouping.

2. Method

2.1. Sample and setting

The REFOCUS Trial was a cluster RCT evaluating a pro-recovery team level intervention (Bird et al., 2011). It took place in adult community mental health teams in two sites: South London and Maudsley NHS Foundation Trust (SLaM) and 2gether NHS Foundation Trust (2gether). Pooled data from both arms were used in the current study. A total of 27 participating teams (18 SLaM, 9 2gether) were recruited, comprising 13 Recovery teams (4 control, 9 intervention), four Psychosis teams (2 control, 2 intervention), three High support teams (1 control, 2 intervention), three assertive outreach teams (3 control), two supported living teams (2 control), one Low support team (1 intervention) and one Early Intervention team (1 control).

All staff providing clinical input to the team were included in the intervention, which was provided to a complete team. A random sample of 15 patients was chosen from each team's caseload. Inclusion criteria were: age 18–65 years, primary clinical diagnosis of psychosis, no immediate plans for discharge or transfer, not currently receiving inpatient care or in prison, speaks and understands English, not participating in substantial other study, in regular contact with at least one worker in the team, and assessed by the clinician as sufficiently well to participate. The intervention was manualised, and involved training staff and supporting behaviour change to lead to more collaborative staff-patient relationships, and a greater staff focus on patient values, strengths, and goal-striving (Slade et al., 2015).

2.2. Measures

We carefully chose a range of measures to span (a) traditional clinical recovery priorities, including needs, symptoms, functioning and quality of life and (b) emerging personal recovery priorities, such as

hope, empowerment and well-being. The selection of measures was informed by existing qualitative research (Bird et al., 2014; Windell et al., 2015) and deliberately wide-ranging because the empirical research to understand the relationship between these outcome domains is limited. Three staff-rated measures and one researcher-rated measures were used. The Health of the Nation Outcome Scale (HoNOS) is a 12-item staff-rated measure of social disability (Wing et al., 1998). The Camberwell Assessment of Needs Short Appraisal Schedule – Staff (CANSAS-S) is a 22-item staff-rated assessment of health and social needs (Slade et al., 2005). The Global Assessment of Functioning (GAF) is a two-item staff rated measure of functioning (Jones et al., 1995). The Brief Psychiatric Rating Scale (BPRS) is an 18-item observer-rated measure of symptomatology which was completed with the patient by research workers (Overall and Gorham, 1998).

Seven patient-rated measures were used. The CANSAS – Service User (CANSAS-P) is a 22-item measure of health and social needs, both staff and service user perspectives are assessed because they have been shown to differ (Slade et al., 1999). The Manchester Short Assessment of Quality of Life (MANSA) is a 16-item rated measure of quality of life (Priebe et al., 1999). The Questionnaire of the Process of Recovery (QPR) is a 15-item measure of personal recovery (Neil et al., 2009). The Mental Health Confidence Scale (MHCS) is a 16-item measure of empowerment (Carpinello et al., 2000). The Herth Hope Index (HHI) is a 12-item measure of client levels of hope (Herth, 1992). The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) is a 14-item measure of well-being (Tennant et al., 2007). INSPIRE is a 27-item measure of recovery orientation of services, with Support and Relationship sub-scales (Shepherd et al., 2014).

All measures used in the study have been previously validated in patients with mental disorders.

2.3. Procedure

Prior to randomisation, informed consent and baseline assessments using all measures were completed at the community base or within the patient's own home. Teams were allocated on an equal basis to intervention or control, and all staff who provided a clinical input to the team were included in the intervention, which was provided to a complete team. The random sample of service users chosen from each team's caseload were approached by their care coordinator, who asked for permission to be contacted by the research team. Patients were re-assessed one year after baseline, using the same measures.

2.4. Analysis

2.4.1. Objective 1

To examine the underlying relationship of the various recovery measures, we conducted an exploratory factor analysis (EFA) on the measures collected at baseline. The EFA was conducted in Mplus 7.2 using Promax rotation. This approach allowed us to reduce the number of measures of interest into a smaller number of factors to be used in the analysis. We assessed the fit of our model to the data with three goodness-of-fit indices: chi-square ($p > .05$), Root Mean Square Error of Approximation (RMSEA $< .06$) and the Standardised Root Mean Square Residual (SRMSR $< .06$). Change scores were calculated subtracting baseline from follow-up scores. To assess trade-off between outcome measures, we explored the correlations across the scales' change scores in Stata 11. Missing data were pro-rated following scale guidelines where available, and otherwise using mean scores where less than 20% of items were missing.

2.4.2. Objective 2

We conducted a confirmatory factor analysis (CFA) on baseline and follow-up data using Mplus 7.2, to compare construct means across these two time points. Prior to conducting the CFA, we tested for measurement invariance to establish whether factor loadings and

Download English Version:

<https://daneshyari.com/en/article/6822653>

Download Persian Version:

<https://daneshyari.com/article/6822653>

[Daneshyari.com](https://daneshyari.com)