From Rhetoric to Routine: Assessing Perceptions of Recovery-Oriented Practices in a State Mental Health and Addiction System

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We would like to dedicate this article in loving memory to Mr. Gerald Croog, whose commitment to ensuring that all persons in recovery receive care that is responsive to their needs and supportive of their individual paths of recovery served as the impetus for this project. He offered us a vision of a system that would be accountable to its constituents and helped to lay the foundation for service system change in Connecticut.

The Recovery Self Assessment (RSA) was developed to gauge perceptions of the degree to which programs implement recovery-oriented practices. Nine hundred and sixty-seven directors, providers, persons in recovery, and significant others from 78 mental health and addiction programs completed the instrument. Factor analysis revealed five factors: Life Goals, Involvement, Diversity of Treatment Options, Choice, and Individually-Tailored Services. Agencies were rated highest on items related to helping people explore their interests and lowest on items regarding service user involvement in services. The RSA is a useful, self-reflective tool to identify strengths and areas for improvement as agencies strive to offer recovery-oriented care.

Over the past few decades, significant advances have been made in the understanding and treatment of psychiatric disorders. Contrary to historical conceptions of mental illnesses, research has demonstrated that recovery from psychiatric disorders is not only possible, but is more than likely for most individuals (Harding, Brooks, Ashikaga, Strauss & Breier, 1987). Recovery is not simply a return to "premorbid functioning," remission of symptoms, or becoming "normal," but rather is about finding purpose and meaning in life, regaining citizenship, and having valued roles, despite one's ailments or disability (Davidson & Strauss, 1992; Deegan, 1996; Ridgway, 2001; Young & Ensing, 1999). As empirical studies and personal stories continue to expand our knowledge about recovery, it becomes increasingly apparent that fundamental changes in the service delivery system are needed to support wellness and recovery from psychiatric disabilities (Sullivan, 1997). This was acknowledged by the U.S. Surgeon General, who called, in his landmark 1999 "Report on Mental Health and Illness," for mental health services to be "consumer-oriented and focused on promoting recovery" (U.S. Department of Health and Human Services, 1999, p. 455).

In addition to a focus on recovery from serious mental illnesses, there has been a national trend toward the use of evidence-based practices. This movement calls for the use of a core set of interventions that have demonstrated effectiveness in decreasing symptoms, enhancing skills, and/or improving

quality of life (Drake et al., 2001). Unfortunately, most people receiving publicly delivered mental health services do not yet receive treatment that is evidence-based (U.S. Department of Health and Human Services, 1999. Drake et al., 2001; Lehman & Steinwachs, 1998; Torrey et al., 2001). This failure to transfer knowledge from the research realm to routine practice settings is well documented in the "call to action" issued by the Institute of Medicine in its report "Bridging the Gap Between Research and Practice" (1998).

In responding to the challenges put forth by the Surgeon General and the Institute of Medicine, the mental health field must incorporate the science of technology transfer to stimulate the widespread organizational change that is necessary for effective and recovery-oriented systems to evolve. What we learn from the science of technology transfer is that the existing gap between research and practice can only be bridged by employing a combination of multifaceted knowledge dissemination tools (Bero et al., 1998; Brown & Flynn, 2002).

Among the variety of tools available to facilitate the evolution of care is the capacity of an organization to make use of ongoing technical assistance and consultation. It is critical that such assistance be extended in the context of a collaborative partnership that has been developed with stakeholders at all levels in the organization. This relationship is the vehicle through which information can be gathered, evaluated, and fed back to the organization for the purpose of program adjustment and improvement. Researchers and consultants must therefore prioritize the cultivation of collaborative evaluation-stakeholder feedback loops (Borich & Jemelka, 1982; Chinman, Weingarten, Stayner & Davidson, 2001; Hatry, Newcomer & Wholey, 1994; Rouse, Toprac & MacCabe, 1998) if they are to be successful in translating the science of recovery-oriented care to routine psychiatric practice.

From Rhetoric to Routine

Many state mental health systems have responded to the challenge of developing more recovery-oriented systems of care, only to be faced with tremendous uncertainties about how to proceed. By integrating more recovery-oriented language—a language of hope, optimism, and high expectations into mission statements, policies, and procedures, it may appear as if states have met the challenge. Because there are few, if any, models of care that have operationalized the principles of recovery into objective practices that can be used to guide, monitor, and evaluate mental healthcare (Anthony, 2000), the extent to which a change in rhetoric is accompanied by a similar change in practice is unclear. For example, one recent review suggested that there has been much old wine poured into the new bottles of recovery language (Jacobson & Greenley, 2001).

In order to begin to address this lack of clarity in the application of recovery principles to reforms in practice, we conducted an extensive review of literature produced by users and providers of mental health and addiction services, researchers, and advocates on the topics of recovery from mental illnesses and addictions. We then identified several common principles of recovery and recovery-oriented systems of care (Davidson, O'Connell, Sells & Staeheli, 2003). In this review, nine principles of recovery were identified: renewing hope and commitment; redefining self; incorporating illness; being involved in meaningful activities; overcoming the effects of discrimination; assuming control; becoming empowered and more involved in one's community and citizenship activities (i.e., voting, paying taxes); managing symptoms; and being supported by others. Recovery-Oriented practices associated with each of these recovery principles were then explored and articulated as a second step in this line of research. In summary, a recovery-oriented environment is one that encourages individuality; promotes accurate and positive portrayals of psychiatric disability while fighting discrimination; focuses on strengths; uses a language of hope and possibility; offers a variety of options for treatment, rehabilitation, and support; supports risk-taking, even when failure is a possibility; actively involves service users, family members, and other natural supports in the development and implementation of programs and services; encourages user participation in advocacy activities; helps develop connections with communities; and helps people develop valued social roles, interests and hobbies, and other meaningful activities. Moving beyond the rhetoric of recovery requires operationalizing these principles into standards and practices that can be observed, measured, and then fed back to mental health organizations in a manner that encourages the use of data to inform program improvement and organizational change efforts.

The Present Study

The purpose of the present study was to assess the degree to which recovery-oriented practices were perceived to be implemented in mental health and addiction agencies funded by the Connecticut Department of Mental Health and Addiction Services using a newly developed tool—the Recovery Self Assessment (RSA). Based on the recovery principles of empowerment and stakeholder involvement in the assessment and development of services, perceptions of recovery-oriented practices were assessed from multiple

perspectives including those of agency directors, direct care providers, persons in recovery, family members, significant others, and advocates. Agency-specific "recovery profiles" were then made available to all participants as part of an ongoing consultation and technical assistance initiative. This initiative assists agencies to build upon their existing strengths and to focus upon areas in need of improvement as they strive to offer recovery-oriented care to the people they treat.

Methods

Procedures

Based on the literature reviews described above, a measure was created to assess the degree to which persons in recovery, providers, family members, significant others, advocates, and agency directors believe their respective agencies engage in a variety of recovery-oriented practices. In the spring of 2002, the instrument was piloted with 148 individuals at 10 agencies receiving state funding.

After piloting and revising the survey, all state-funded facilities that provide adult mental health and addiction services in Connecticut were identified as sites for data collection (*N*=208). Agency directors were sent a cover letter, instructions for disseminating the survey, and 16 copies of the survey (1 Agency Director version, 5 Provider versions, 5 Persons in Recovery versions, and 5 Family Member/Significant Other/Advocate versions). Directors were instructed to complete the Agency Director version and to disseminate the Provider versions to 5 agency providers. These providers were then asked to each identify one person in recovery and one family member, significant other, or advocate who knew the agency's services well to complete the Person in Recovery and Family Member/Significant Other/Advocate version. A total of 3,328 surveys were mailed to agency directors across the state. Participation was voluntary and completion of the questionnaire was considered written informed consent.

Sample

Participants included 974 individuals (individual response rate of 29%) from 82 of the facilities (39% agency response rate). Four agencies and corresponding respondents (*n*=7) were eliminated from the analysis due to the following reasons: a) three agencies only had one respondent and b) all respondents at the fourth agency did not complete at least two-thirds of the items. The breakdown of the participants in the remaining 78 agencies was: 68 Directors, 344 Providers, 326 Persons in Recovery, and 229 Family Members/Significant Others/ Advocates.

Measures

The Recovery Self Assessment (RSA) was developed for the present research as a tool to provide state programs with a method of gauging the degree to which constituents believed that their programs implement practices that are consistent with the principles of recovery. An initial pool of 80 items was generated based on the nine domains of recovery identified in the literature (Davidson et al., 2003). The items reflect objective practices that are associated with the conceptual domains of recovery. For example, indicators such as the involvement of service users in management meetings and staff education, activities geared towards expanding social networks and social roles, degree of service user choice and self-determination, and staff attitudes and philosophy towards recovery were included in the measure. Items contained the term "persons in recovery" when referring to individuals recovering from mental health, addiction, and/or co-occurring problems. All items consisted of a brief statement with a six-category Likert response format from 1 (strongly disagree) to 5 (strongly agree) or N/A (not applicable). Persons in recovery, providers of mental health and addiction services, family members, and researchers with expertise in measurement development and clinical and community psychology reviewed all items for content and comprehension. Items were then edited, balanced with regard to conceptual domain, and eliminated until 36 items remained. The items on the RSA were then adapted for completion by providers/directors, persons in recovery, and family/significant others/advocates by changing the point of reference on each item (i.e., "staff at this agency focus on helping me" versus "staff at this agency focus on helping persons in recovery").

Analysis

Item scores on the RSA were entered into a principal components factor analysis and subjected to Varimax rotation. The optimal number of factors was determined by an examination of the screen plot and a criterion of having an eigenvalue greater than one. Alpha coefficients of internal consistency were computed for each factor. A factor score was computed based on the mean of each group of items. An RSA summary score was derived by computing the mean of all 36 items. At the individual level of analysis (*N*=967), the factor scores and RSA summary scores were entered into a series of ANOVAS to examine differences in scores as a function of respondent category. The RSA summary scores and factor scores were then aggregated to the level of the agency (*N*=78), where agency averages were plotted onto histograms. The histograms were used to provide specific agencies with information about their relative standing in comparison to other participating agencies on the RSA summary score and factor score.

Table 1—Sample RSA Items and Factor Loadings

Item #	Item	Loading
Factor 1: Life Goals		
25	Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization.	.73
29	Staff routinely assist individuals in the pursuit of educational and/or employment goals.	.66
33	The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations.	.61
Factor 2: Involvement		
30	People in recovery work alongside agency staff on the development and provision of new programs and services.	.75
27	People in recovery are regular members of agency advisory boards and management meetings.	.74
15	Persons in recovery are involved with facilitating staff trainings and education programs at this agency.	.71
Factor 3: Diversity of Treatment Options		
34	Criteria for exiting or completing the agency are clearly defined and discussed with participants upon entry to the agency.	.54
18	This agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs.	.53
19	This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose.	.52
Factor 4: Choice		
3	People in recovery have access to all their treatment records.	.62
13	Agency staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices.	.59
10	Staff at this agency listen to and follow the choices and preferences of participants.	.56
Factor 5: Individually-Tailored Services		
2	This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs.	.65
9	All staff at this agency regularly attend trainings on cultural competency.	.58
1	Helping people build connections with their neighborhoods and communities is one of the primary activities in which staff at this agency are involved.	.55

Results

RSA Factors

The 36 items on the RSA fell into five components and accounted for 53.8% of the total variance in the sample. Table 1 contains sample items and item loadings for each of the five factors.

Higher factor scores reflect greater agreement with the items in that factor.

A first factor, "Life Goals" contains 11 items that reflect perceptions of the extent to which staff help with the development and pursuit of individually defined life goals such as employment and education. This factor accounted for 13.7% of the total variance in the sample. The internal consistency estimate for this factor was .90.

A second factor, "Involvement," contains 8 items reflecting perceptions of the extent to which persons in recovery are involved in the development and provision of programs/services, staff training, and advisory board/management meetings. This factor accounted for 13.3% of the total variance in the sample. The internal consistency estimate for this factor was .87.

A third factor, "Diversity of Treatment Options," contains 6 items that indicate perceptions of the extent to which an agency provides linkages to peer mentors and support, a variety of treatment options, and assistance with becoming involved in non-mental health activities. This factor accounted for 9.8% of the total variance in the sample. The internal consistency estimate for this factor was .83.

A fourth factor, "Choice," contains 6 items measuring perceptions of the extent to which service users have access to their treatment records, staff refrain from using coercive measures to influence choice, and the choices of service users are respected by staff. This factor accounted for 8.9% of the total variance in the sample. The internal consistency estimate for this factor was .76.

The final factor, "Individually-Tailored Services," contains 5 items that reflect perceptions of the extent to which services are tailored to individual needs, cultures, and interests, and focus on building community connections. This factor accounted for 8% of the total variance and had an internal consistency estimate of .76.

Differences in Perceived Recovery-Oriented Practices by Respondent Category

A series of Analysis of Variance (ANOVA) techniques were used to examine scores on the five factors and

Table 2—Means and Standard Deviations for RSA Summary Score and Factor Scores

	Directors (*n*=68) Mean (*SD*)	Providers (*n*=344) Mean (*SD*)	Persons in Recovery (*n*=326) Mean (*SD*)	Family/ SO/ Advocates (*n*=229) Mean (*SD*)	Total Sample (*N*=967) Mean (*SD*)
Summary Score	4.09 (.42)	3.87 (.62)[a]	4.06 (.69)[b]**	4.00 (.77)	3.98 (.67)
Life Goals	4.36 (.44)[b]*	4.10 (.66)[a]	4.21 (.70)	4.16 (.78)	4.17 (.70)
Involvement	3.56 (.74)	3.39 (.80)[a]	3.79 (.91)[b]**	3.79 (.93)[c]**	3.62 (.88)
Diversity of Treatment Options	4.23 (.51)	3.95 (.78)	4.02 (.91)	4.00 (.87)	4.00 (.83)
Choice	4.29 (.53)	4.08 (.69)	4.14 (.82)	4.06 (.80)	4.11 (.76)
Individually-Tailored Services	3.91 (.61)	3.82 (.79)[a]	4.01 (.81)[b]*	4.05 (.83)[c]**	3.94 (.80)

Notes.

a score is significantly lower than b and c

* $p<.05$, ** $p<.01$

the RSA summary score as a function of respondent category (director, provider, person in recovery, and family/significant other/advocate). Results indicate that service providers had significantly lower ratings than persons in recovery on the RSA summary score, $F(3,912) = 5.03$, $p=.00$. On the individual factors, ANOVAs revealed that service providers had significantly lower scores than directors on *Life Goals,* $F(3,934) = 2.97$, $p=.03$. Providers also had significantly lower scores than persons in recovery and family members/significant others/advocates on *Involvement,* $F(3,894) = 14.36$, $p=.00$, and *Individually-Tailored Services*, $F(3,934) = 4.70$, $p = .00$. There were no significant differences between the various categories of respondents on *Choice* or *Diversity of Treatment Options*. See Table 2 for the means and standard deviations of factor scores for each of the respondent categories.

Recovery Profiles

The individual-level data were aggregated to the level of the agency (*N*=78). The average factor scores and the average RSA summary score were computed for each of the agencies and were displayed in histograms that contained the normal curve and lines demarcating standard deviations. The histograms showed a relatively normal distribution of average scores on the RSA summary score and factor scores with approximately 65% of the agencies falling within one standard deviation above or below the mean and approximately 95% falling within two standard deviations above or below the mean.

An individual, confidential Recovery Profile was created for each agency that desired such a report. The Recovery Profiles contained the histograms described above with the respective agency highlighted in yellow. These histograms allowed individual agencies to view their relative standing in comparison to other participating agencies (see Appendix A for a sample Agency Recovery Profile). Each Recovery Profile also contained a brief description of the agency's sample and a description of relative strengths (factors and items more than 1 standard deviation above the state average) and areas for improvement (factors and items more than 1 standard deviation below the state average). Finally, each Recovery Profile contained an individual item analysis of the five highest rated recovery-oriented practices at the agency and the five lowest rated items (based on the average scores of all respondents).

Discussion and Conclusions

As state mental health systems begin to shift from traditional mental health treatment to models of care that focus on supporting an individual's recovery, it is imperative that the redefinition goes beyond rhetoric into actual changes in practice. A common challenge emerges in this translation—there are few, if any, models of care that have operationalized the principles of recovery into objective practices. The present study contributes to this effort in several ways: a) it is the first known statewide assessment of perceptions of recovery-oriented practices; b) it involved the development of an inventory that can be used by service systems to assess perceptions of practices that are considered to be consistent with a recovery-orientation from multiple perspectives; and c) it provides an illustration of how research can be translated into everyday prac-

tice through the use of self-assessment and structured feedback.

Results indicate mental health professionals, persons in recovery, and family members generally agreed that their agencies were providing services that are consistent with a recovery orientation. It is encouraging that the highest rated items were those related to services focusing on helping people explore their own goals and interests beyond symptom management. Agencies, however, were rated lowest on items regarding involvement of service users in service design, management, and provision. This finding is consistent with the literature indicating that one of the most difficult barriers for practitioners in recovery is being accepted as equal members of agency staff (Mowbray, Moxley, Jasper & Howell, 1997).

It is important to note that, despite overall favorable responses, when examining agency ratings as a function of role in the mental health system, providers gave significantly lower ratings on three of the five factors. This finding indicates a degree of disconnect between the various stakeholders in the field about what is actually occurring in everyday practice. The consistently higher ratings by persons in recovery may indicate that they perceive recovery-oriented practices to be occurring in their agency. However, these higher service user ratings may also reflect common difficulties that occur in conducting service user satisfaction surveys. For example, there may have been a selection bias due to the fact that agency directors and providers hand-selected the respondents. Providers could have chosen persons in recovery who were actively engaged in treatment and other activities outside of the system, and thus were more likely to rate these services highly. Another problem that occurs in service user surveys is that people only know that to which they have been exposed (Davidson, Hoge, Godleski, Rakfeldt & Griffith, 1996). If someone is not familiar with alternatives, it is easier to be satisfied with what he/she has. It should be noted that the ideal administration of the RSA is one that a) is administered consistently across sites, program participants, and staff; b) maintains anonymity of respondents; and c) assesses the majority of the program participants/staff. This would help to reduce some of the self-selection bias as well as allowing for the most accurate description of perceptions of recovery-oriented practices at the each agency.

In addition to the limitation of the lack of randomized selection of respondents within agencies, data on construct and external validity of the RSA is not available at this time because it was administered as a single inventory. In the future, research should be conducted to examine scores on the RSA in relation to other recovery-oriented constructs such as quality of life, satisfaction with services, and empowerment to determine if persons in recovery receiving services at agencies that score higher on the RSA in fact have better individual outcomes. Furthermore, because the items are written to assess perceptions of measurable indices of a recovery-oriented system of care, future research should also examine the degree to which the subjective perceptions of recovery-oriented practices are consistent with the actual implementation of the practices and more objective measures of fidelity (i.e., data available in chart reviews, policies, and procedures).

Despite these limitations, the attempt to operationalize and measure practices that could be supportive of a person's recovery was embraced by the provider community with much enthusiasm. Much of the feedback received indicated that providers were hungry for tools that would enable them to enhance the recovery orientation of the care they provided. Since the study, the items in the RSA have served as the impetus for much discussion among stakeholders in mental health and addiction programs about the meaning of recovery and recognizable practices. Based on these discussions, separate models of recovery pertaining to mental health and/or addictions and standards of care have been developed at the level of the state to help practitioners learn to differentiate recovery-oriented practices from non-recovery oriented practices. The dissemination of findings within agencies has also helped to identify discrepancies in perceptions within organizations that may be attributed to a lack of communication or misunderstanding (i.e., persons in recovery often indicated that they did not have access to their treatment records, whereas providers and directors often indicated the opposite). Thus, the Recovery Self Assessment is not only a useful, self-reflective tool for agencies to begin to identify strengths and target areas for improvement as they strive to offer recovery-oriented care to the people they treat, but it is an effective tool to help strengthen collaborative evaluation-stakeholder feedback loops.

Appendix A: Sample Mental Health Center Recovery Profile

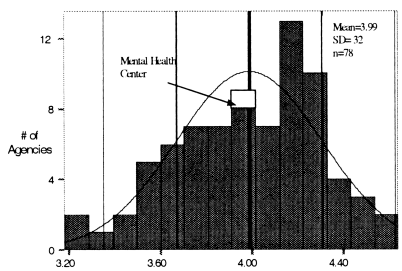
MENTAL HEALTH CENTER

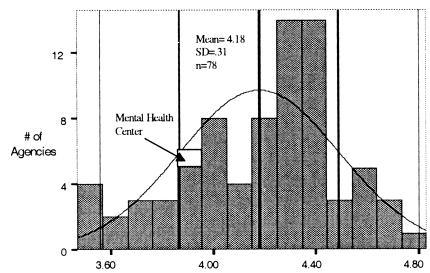
Agency Recovery Profile

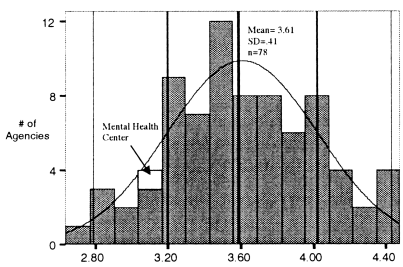
Mental Health Center Respondents:

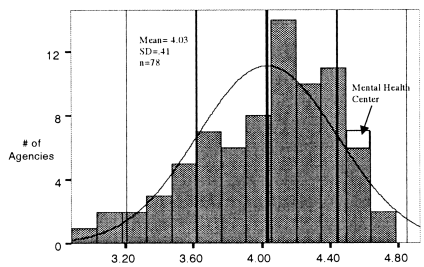
- 1 Director/CEO
- 5 Providers/Direct Care Staff
- 5 Persons in Recovery
- 5 Family/S.O./Advocate

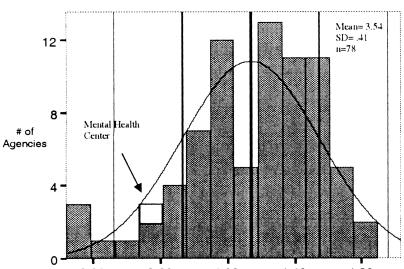
Comparisons to other state agencies

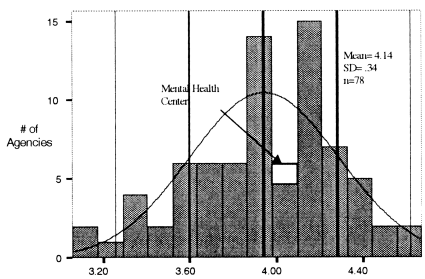












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Appendix B

MENTAL HEALTH CENTER

Agency Recovery Profile

Strengths and Areas for Improvement

Strengths

5 Highest Rated Items by respondents at your agency

- Staff do not use threats, bribes, or coercion
- Natural supports are involved in the planning of services
- Sexual and spiritual needs are discussed
- Progress in goals in monitored regularly
- Procedures are in place to facilitate outside referrals

Other Strengths (in comparison to other agencies)

Providing a Diversity of Treatment Options

- *linking people to peers*
- *having clearly defined exit criteria*
- *flexibility in scheduling*
- *people doing well get as much attention as others*

Areas for Improvement

5 Lowest Rated Items by respondents at your agency

- People in recovery help with the development and provision of services
- People in recovery can choose their service providers
- Education is provided to community employers
- People in recovery are regular members of advisory boards and management meetings
- Staff help people become involved in activities to give back to their communities

Other Areas for Improvement (based on comparisons to other agencies):

Involvement in the provision of programs and services:

Ways to improve in this area:

- Hiring practitioners in recovery
- Having people in recovery sit on advisory boards and management meetings
- Have persons in recovery co-facilitate staff trainings
- Use consumer expertise as part of educational programs
- Persons in recovery should be included in all program/staff evaluation procedures
- Formally celebrate/acknowledge achievement of goals by staff and persons in recovery

Other Suggestions:

- *provide education to community employers about mental illness and recovery*
- *allow people to choose their service providers*
- *do more to focus on career and life goals, including employment and education*

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