# Recovery - Oriented Care for Older People: Staff Attitudes and Practices

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## Abstract
There is a push to change the focus of mental health delivery from symptom reduction to recovery orientation where self-determination and choice are central to programmes. Whilst there is a robust literature on recovery definition, assessment and training, this has not been matched with studies of recovery with older adult consumers or staff working in older adult settings. The purpose of this sequential explanatory study was to identify the recovery attitudes and practices of the staff from the Sydney Local Health District Specialist Mental Health Service for Older People (SMHSOP), Australia. Fourteen members of staff completed two self-report recovery measures and subsequently took part in focus group interviews. Results of this mixed methods study suggested that whilst mental health staff in this sample supported the self-definition and individuality aspects within the recovery model, risk management remains problematic with this population. Clinical experience mediated the extent of knowledge and practices within a recovery framework. Barriers to implementing recovery oriented practice included client incapacity and the expectation of consumers. The suitability of current recovery concepts and measures to older populations is discussed.

**KEY WORDS:** recovery, older adults, staff attitudes, mental health

## Introduction:
Recovery has become the guiding principle of public mental health care delivery, in recognition of the lived experience and needs of consumers (Commonwealth of Australia, 2013; Tse & Barnett, 2009). The focus of care has shifted from the clinical treatment model in which mental illness symptoms had to be treated or cured to one of

collaborative care with self-determination, power, meaning and hope as its key features (McKenna, Furness, Dhital et al, 2014). One definition of personal recovery is "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Commonwealth of Australia, 2013, p. 25). Australia's Fourth National Mental Health Plan has determined that recovery oriented principles be a priority (Burgess, Pirkis, Coombs et al, 2011). However, the concept of recovery is a complex one that can be challenging to implement. This can be seen as a barrier to adopting recovery practices in health care. A large body of literature exists on recovery approaches to care in adults, including evaluation of recovery programs for consumers. A study of United States veterans and clinicians highlighted positive endorsement of recovery oriented practice, with the study design enabling quantitative comparison of recovery orientation amongst different programs for veterans (Leddy-Stacy, Stefanovics & Rosenheck, 2016). Key concepts promoting recovery oriented care such as knowledge about recovery in mental health professionals have also been identified (Wilrycz, Croon, van den Broek et al, 2012; Bedregal, O'Connell & Davison, 2006). Qualitative studies of recovery have echoed the importance of knowledge of recovery relating to recovery oriented practice (Piat & Lai, 2012). Other themes related to recovery emerging from qualitative analysis methodology such as clinician focus groups, include positive views of the future and supporting individual goals, as opposed to clinician led disease focused plans (Dalum, Pedersen, Cunningham et al, 2015). A common feature from studies examining recovery orientation, regardless of methodological approach, is the need for a consistent definition of recovery with examples of how to support recovery reform (Happell, Byrne & Platania-Phung, 2015; Piat & Lal, 2012).

## Recovery and older clients

Despite demographic projections of increased demand for mental health services in older adult consumers (McKenna et al, 2014), there is very little research regarding recovery in either clinicians working with older consumers or amongst the older consumers themselves. Studies that have addressed recovery oriented care models with older clients have utilized purely qualitative methodology. A Spanish study utilizing qualitative grounded theory research methodology examined recovery in nursing homes by interviewing care staff. However the sample size was very small (ten), limiting generalizability. The investigators illustrate important cultural factors positively influencing recovery oriented practice in nursing home environments, in particular social interactions with residents whilst delivering daily care (Saavedra, Cubero & Crawford, 2012).

A review of applying recovery oriented principles to older adults highlighted maintaining identity and coping with physical illness as key concepts pertaining to older adults, following grounded theory analysis of thirty-eight interviews with consumers of an older adult mental health service. In addition, the study found components of recovery that relate to dementia: changing experience over time and support (Daley, Newtown, Slade et al, 2013).
An Australian study utilized qualitative focus group methodology to explore how recovery philosophy was translated into everyday care in their older adult inpatient unit (McKenna et al, 2014). This study of the views of twelve mental health nurses is of value due to addressing the challenges of recovery with older adults. Providing hope within the context of physical frailty and maintaining current level of daily self-care and engagement were key recovery domains emerging from inductive data analysis following interview coding.

To date, there is no study of recovery with older adult consumers or staff working in older adult settings utilizing mixed methods research methodology. This is of concern, given the broad nature of attitudes and the lack of consensus regarding the definition of recovery. In triangulating results, mixed method research has the potential to explain quantitative findings regarding attitudes towards recovery, identify barriers and illuminate recovery concepts from stakeholders' perspectives. The projected rise in the ageing population underscores the attention required to recovery oriented practice with older adults. Older adults need to have a voice in their own mental health care in light of ageist attitudes in health care. Studies have found age differentiated behaviour amongst health care practitioners, with less emphasis on psychosocial issues in older consumers, when compared to those under the age of 65 (Pasupathi & Lockenhoff, 2002).

# The present study

The purpose of this study was to identify the recovery attitudes and practices of the staff from the Sydney Local Health District Specialist Mental Health Service for Older People (SMHSOP) in Australia. The project aimed to firstly directly quantify the attitudes, knowledge and recovery practices of community mental health staff utilizing two scales. This was followed up by a qualitative strand involving grounded theory analysis of focus group interviews with the staff in order to better understand questionnaire findings. This project is the initial step in a central change issue for mental health services: "reorienting existing services to enable the recovery approach to be put into practice' (Tse & Barnett, 2009 p.96).

# Research Question

The central question is asked: What are the attitudes and practices of mental health clinicians working in older adult settings towards recovery oriented practice? What is the current level of recovery oriented knowledge within the Specialist Mental Health Service for Older People? How will information emerging from staff focus groups help illuminate the barriers to implementing recovery oriented practice within an older adult mental health setting? Are there unique aspects of recovery specific to older adults?

# Method

## Design:

A mixed methods explanatory sequential design was performed, comprising both quantitative and qualitative approaches. This allowed for triangulation where areas of convergence can be identified (Bryman & Bell, 2003). The quantitative strand of the study consisted of a cross-sectional survey. Given this is a study in perceptions of recovery, a qualitative, inductive approach aimed to enrich initial quantitative findings.

## Measures:

The measures consisted of two standardized questionnaires that have been thoroughly researched in the literature and found to have good validity and reliability (Hungerford, Dowling & Doyle, 2015; Burgess et al, 2011; Campbell-Orde, Chamberlin, Carpenter et al, 2005). Both use Likert scales with responses ranging for 1 to 5 in terms of rating extent of agreement with the statement.

**The Recovery Knowledge Inventory (RKI) (Bedregal, O'Connell & Davidson, 2006).**

This 20 item questionnaire measures the knowledge and attitudes towards recovery within mental health professionals. The tool can highlight areas of recovery that are less familiar to staff, thereby directing future training in recovery oriented practices.

Several factors have emerged from psychometric evaluation of the tool including "Roles and Responsibilities", referring to consumer attitudes regarding consumer and staff member roles in recovery, "Non-linearity of the Recovery Process", involving concepts and stages of symptom management, "Role of Self-determination and Peers in Recovery", referring to identifying beyond one's mental illness and including the role of peers and activities, with "Expectations Regarding Recovery" being the final factor (Bedregal et al, 2006). Cronbach's alpha has been reported as at least 0.6 for these factors (Repique, Vernig, Lowe et al, 2016). An Australian study of nurses suggested a lack of consistency regarding the meaning of the term 'recovery' (Happell, Byrne & Platania-Phung, 2015). Studies have utilized the RKI as a means of identifying aspects of recovery that are less familiar to staff, thereby directing future training in recovery oriented practices (Bedregal et al, 2006). Another Australian study has validated its use both in terms of sensitivity in evaluating training and internal validity for cultural appropriateness in Australian mental health service contexts (Hungerford, Downing & Doyle, 2015).

**The Recovery Self-Assessment (RSA-R) Provider version (O'Connell, 2007; O'Connell, Tondora, Croog et al, 2005)**

This 32 item tool evaluates the degree of recovery oriented practices within a mental health care setting. Five factors are contained within the original scale, namely Life Goals (or how much staff help consumers develop and pursue individual life goals), Consumer Involvement (or the extent to which consumers are represented across several levels of mental health services including the development of programs and representation on advisory boards), Diversity of Treatment Options (the extent to which a service offers a range of therapeutic options including peer support services and non-mental health interventions) Client Choice ( includes facilitating access to medical records and less use of coercion) and finally Factor 5 refers to Individually Tailored Services (or services aligned with an individual's culture and interests). The internal consistency of all five factors identified in the initial study was at least 0.76 which is considered robust (O'Connell et al, 2005). The tool is particularly attractive in that it can also yield a recovery profile for each factor. This provides the agency with a guide as to its strengths and weaknesses in working within a recovery oriented framework. Several versions have been developed of this tool, including a revised self-assessment practitioner version (item example: "staff and agency participants are encouraged to take risks and try new things"), including two new items corresponding to a sixth, "Inviting" factor (O'-Connell, 2007). The RSA met all six criteria (for example, is manageable in terms of administration, is acceptable to consumers, has been scientifically scrutinized) to recommend its routine use in Australian mental health settings (Burgess et al, 2011).

The survey also contained demographic items indicating age range, designation and any previous training in recovery training.

## Subjects and Procedure

In order to ensure informed consent and maximize response rate, the staff of the Specialist Mental Health Service for Older People were informed about the study approximately one month in advance at the beginning of the weekly clinical case review meeting. The hardcopy paper based questionnaire was piloted for layout, timing and readability, with two administrative officers of the SMHSOP team prior to commencement of the study.
An information sheet accompanied the survey, distributed just prior to the weekly case review meeting when all team members were present. The survey was accompanied by an envelope to be returned to the principal researcher within one week. This was to minimize group pressure and researcher influences in responses to items on the questionnaires and ensure anonymity.

The qualitative component of the study consisted of focus group interviews. Two focus groups were conducted separately at two separate health centers with SMHSOP staff being a purposive sample. The team health promotion officer was a co-analyst and transcriber of the data and its coding in order to maximize reliability and validity (for example, addressing the potential for recall bias).

## Data analysis

The quantitative data collection time point was at the beginning of the study, prior to the qualitative focus groups. This time frame was chosen in order to avoid any measurement error or bias from material emerging from the focus groups that may contaminate responses to the questionnaires. It is also consistent with an explanatory sequential design with qualitative data adding to quantitative results.

The quantitative strand of the mixed methods research involved descriptive statistics performed via SPSS -21 (IBM, 2012), calculating means, standard deviations ranges and medians as appropriate. Non parametric Spearman correlations were calculated to examine interrelationships between variables, including the two questionaries.
Analysis of qualitative data consisted of interview transcripts being hand coded, using open coding of themes or categories of information (Liamputtong & Serry, 2014; Starks & Trinidad, 2007). Themes were then developed into axial codes and further analysed and reduced into selective codes, with the aid of NVivo software (Gibbs, 2008). Codes were crosschecked with the health promotions officer.

## Ethical considerations

Participants were informed of the anonymous nature of the study with written consent obtained. The confidential nature of responses was again emphasized at the commencement of each focus group. The study was approved by the Sydney Local Health District human research ethics committee (Royal Prince Alfred Hospital Zone).

# Results

## Subjects:

The 14 team members of the Campderdown and Canterbury Specialist Mental Health Service for Older People (SMHSOP) of Sydney Local Health District (SLHD) all participated in the research. 43% of participants were female. In terms of professional background, half the sample were nurses, with 29% being social workers and 22% from the medical profession. 57% had reached senior professional grades (for example, clinical nurse specialist). 36% of the sample had less than 5 years' experience in mental health with 28.6% having over 20 years experience.

Recovery Knowledge Inventory

**TABLE 1 Recovery Knowledge Inventory Domain Scores**

| Factors | Mean | (SD) N=14 |
|---|---|---|
| **Roles and Responsibilities in Recovery** | **4.01** | **(0.49)** |
| **Non-Linearity of the Recovery Process** | **3.29** | **(0.72)** |
| **Roles of Self-definition and Peer Support** | **4.06** | **(0.35)** |
| **Expectations Regarding Recovery** | **3.15** | **(1.1)** |

The highest endorsed RKI items by sample were reported as:
-"Pursuit of hobbies and leisure is important for recovery (M= 4.5; SD =0.52)

-"Defining who one is, apart from their condition, is an essential component of recovery" (M= 4.5; SD =0.76)

The lowest endorsed knowledge items by sample were:
"Symptom management is the first step towards recovery from mental health illness/substance abuse" (M= 2.79; SD =1.2).

"Not everyone is capable of actively participating in the recovery process" (M =2.9; SD =1.39).

There were significant intercorrelations between the Roles and Responsibilities domain score on the RKI with Expectations Regarding Recovery sharing nearly 50% of variance (Spearman's Rho r = 0.691) and Non-Linearity of the Recovery Process sharing 35.5% of variance (Spearman's Rho r = .596).

Recovery Self –Assessment Scale-Revised

**TABLE 2 Recovery Self-Assessment Sub-Scale Scores**

| Factor | Mean | Standard Deviation N=14 |
|---|---|---|

| Life Goals | 4.32 | (0.50) |
|---|---|---|
| Involvement | 2.74 | (0.84) |
| Diversity of Treatment Options | 2.41 | (0.49) |
| Choice | 3.58 | (0.45) |
| Individually - Taylored Services | 3.62 | (0.43) |
| Inviting | 3.35 | (0.62) |

Of note was the high number of missing values where 72% (23/32) of questions contained missing items, most commonly rated as “not applicable”. The majority of missing items loaded on the Life Goals (for example, “Staff routinely assist individuals in the pursuit of educational and/or employment goals”) and Involvement factors (for example, “People in recovery are regular members of agency advisory boards and management meetings”).

The highest endorsed items by the sample on fully completed scales were:
“Agency staff do not use threats or bribes or other forms of coercion to influence a person’s behaviour or choice” (M= 4.36 SD =0.84) and “Agency staff believe people can recover and make their own treatment and life choices” (M = 4.15 SD = 0.37).

The least endorsed item was “People in recovery have access to all their medical records” (M=2.1 SD =0.8).

There were no significant relationships between both scales and demographic items, based on Kruskal-Wallis tests of significant. A significant negative correlation was obtained between the Individual-Tailored Service factor on the RSA and years worked (r= -0.71 or 50 % shared variance).

**FOCUS GROUPS MAIN THEMES**
Four main themes emerged from qualitative analysis of focus groups:

1 Power/choice: Respondents referred to ongoing issues relating to directing patient care and choices. For example: “Its just so easy to be directive in the kind of relationship that I have with my patients, I actually have a lot of power” (Registered Nurse); “Its being paternalistic, but you know what’s good for them (Consultant)”; “There is an expectation that we will come up with the answers” (Social worker).”

2. Risk: Respondents reported struggling with risk and that this impeded adopting a recovery oriented approach to care. They spoke of the risk averse culture of the service and fearing adverse events if they relinquished control to consumers. For example: “Risk is inherent in recovery; we’re not allowed to sit with risk” (Consultant); “Services like ours are fairly risk averse in terms of establishing goals for clients” (clinical nurse specialist).

3. Language and culture: Actual definitions of recovery and how this translated into care planning was discussed by respondents with an attitude that it was not necessarily such a new concept in practice. For example: “I think we’re doing it but we never called it recovery” (clinical nurse specialist); “Just because we changed the words, does that mean we weren’t doing it in the first place?” (Consultant).

4. Capacity and insight: Consumers' ability to make decisions and set goals was an issue discussed in focus groups in an environment where many consumers have cognitive impairment and require substitute decision making. This issue of capacity was defined as a practical, concrete barrier to adopting recovery oriented care. For example, "They need help to make informed decisions around their recovery" (Senior social worker); "Mental health acts, continued treatment orders and other forms of involuntary care like the Guardianship Act are needed especially with our clients because they may lack capacity" (Registered Nurse).

Several other barriers also emerged from analysis of qualitative responses related to resource limitations, including clinician time availability, organizational expectations of working within a medical model of symptom reduction, and client/family role expectations of being a passive recipient of care: "The client themselves are a barrier to recovery" (Registered Nurse).

## Discussion

This study aimed to examine recovery oriented knowledge and attitudes amongst mental health professionals working in older adult community settings. Knowledge of recovery in this sample highlighted a similar pattern to other studies, with other age groups also sharing the present sample's low expectation regarding recovery (Gaffney & Evans, 2016). The importance of self-definition beyond one's mental illness appears to be highly endorsed, again across age populations with this factor having high scores in the present and other studies utilizing the Recovery Knowledge Inventory (Repique et al, 2016; Daley et al, 2012). The present sample indicated their support for individually tailored services for their clients, underscoring the heterogeneity of older populations and the importance of collaboration with `the broader system surrounding the consumer, distinct in older person's mental health settings (McKenna et al, 2014). The involvement of significant others such as nursing home staff, community support staff and family members is essential to positive therapeutic outcomes. Of interest is the negative relationship between clinical experience and a focus on client input and involvement with other agencies. In contrast to other qualitative findings (Dalum et al, 2015; McKenna et al, 2014), the present study failed to identify hope as an element of service provision. The qualitative data in the present results suggest an element of paternalism in attitudes towards older consumers, a risk averse culture and continuing staff ownership of interventions. As in other studies (Happell et al, 2015), the concept of recovery is questioned, with staff not supporting a specific need to change their practices in terms of recovery: "Just because we changed the words, does that mean we weren't doing it in the first place?"

Examination of barriers to utilizing a recovery focus illuminate the present findings with the cognitive capacity of clients and current service provision models identified as barriers to a person-centred, choice approach. Clinicians also suggested that the expectations of clients and their families may be colluding with a more traditional approach to mental health care with a focus on treating an illness. The significant poor completion rate of items of the Recovery Self-Assessment, in particular those items relating to life goals and consumer involvement factors, is congruent with such a finding. High rates of co-morbidity with medical conditions and dementia in older age groups further strengthen such attitudes of dependence on health services.

Hence it appears that there is tension between providing an individually based service promoting self-determination, hope and choice and the practical need for substitute decision makers on account of factors such as cognitive and physical incapacity. The need to include the consumer's broader system, (whilst an important element of recovery oriented care), can also paradoxically decrease the older consumer's autonomy. Results from qualitative investigation into concepts of recovery in older populations have dis-

cussed recovery components for people with dementia, confirming the need for external support (Daley et al, 2013). However the present study highlighted some differences in recovery concepts relating to the needs of older adults, particularly in the area of life goals and involvement. The large inter-correlations between factors on the Recovery Knowledge Inventory are suggestive that its underlying constructs may be different in older populations, based on the present study.

This may be a cohort effect with current older populations that may shift in the future. A decrease in the stigma of mental illness through education and the increase in “baby boomer” consumers more comfortable with psychological issues may have future impacts on these barriers to recovery oriented care. However the present findings question the suitability of current recovery concepts and their measurement with older adults. The importance of individual interest and identity appears to be a stable concept across ages based on the present findings. However this does not appear to extend to broader avenues for representation such as advocacy on advisory boards. Opportunities for pursuing employment goals or facilitating education programs may be rare in the present clinical setting. The role of cognitive impairment and mechanisms of protection such as Guardianship also need to be considered in the context of recovery oriented care practices. The present study also raised the issue of risk management: a common dilemma in recovery oriented practice implementation (Gaffey & Evans, 2016), here possibly relating to low endorsement of hope. The inverse relationship between individually tailored services and clinical experience, together with the qualitative theme of power, raises issues around paternalism and even possible burnout amongst more experienced clinicians. Time poor clinicians faced with complex clinical presentations may resort to making decisions on someone’s behalf.

Limitations of the present study and future directions

This study was limited to the staff of one mental health older adult service, restricting generalizability. A larger sample is needed that also includes consumers. Conducting confirmatory factor analysis can examine applicability of recovery constructs to older populations. The poor response completion rate on the RSA also limits interpretation of findings, as well as questioning its suitability for older adult populations. Further factor analytic research with the RSA and a larger cohort of both professionals and consumers of older adult mental health services may illuminate the specific issues relating to the practice of recovery oriented care with older adults. The present study supports the development of a recovery oriented self-assessment tool specific to older adult settings. This may guide guiding service provision towards hope and higher expectations regarding recovery, whilst including important people and services in the consumer’s environment.

# Conclusion

Whilst older persons mental health staff, in the present study, endorse the need for individually tailored services and maintaining interests external to their illness, they also have to balance this with individual and service based barriers to the practice of recovery oriented care. This study has highlighted the unique issues of recovery orientation with older consumers and the need for recovery concepts that address their specific needs. Further identification of these issues from studies with larger samples may then be translated into suitable recovery definitions, policy and practice, thus promoting recovery oriented care across the life span.

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