

2016

Correlates of the Perception of Recovery-Oriented Treatment in an Inpatient Setting

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Philadelphia College of Osteopathic Medicine

Department of Psychology

CORRELATES OF THE PERCEPTION OF RECOVERY-ORIENTED TREATMENT
IN AN INPATIENT SETTING

Beau Brendley

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Psychology

June 2016

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY**

Dissertation Approval

This is to certify that the thesis presented to us by Beau Brendley on the 9th day of May, 2016, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Acknowledgements

I would like to send my deepest gratitude and appreciation to my dissertation committee for helping me to create and complete this dissertation.

To Bruce Zahn, you have been behind me throughout my time at PCOM. I cannot begin to thank you enough for your support, agreeing to become my Chair, and helping me complete my dissertation. I appreciate all that you have done to help mentor me to become a psychologist.

To Petra Kottsieper, thank you for helping to design a study that is congruent with my morals while always being patient and encouraging throughout my career. Thank you for introducing me further to the recovery model as well as how to implement theory into action.

To Dr. Poteau and Dr. Vernig, thank you for agreeing to participate on my committee and provide me with valuable feedback.

Thank you to the staff and patients at Friends Hospital for assisting me complete my study.

Thank you to Dr. Di Tomasso, who helped me with my statistics.

Thank you to the whole teaching staff at PCOM for your invaluable support, especially through difficult times.

Thank you to Intercommunity Action and Dr. William La Valle and Dr. Michael Gray for being flexible, supportive mentors and helping me to develop into a competent psychologist.

Thanks to Tara and the other PCOM externs who have supported me through a lot.

Thanks to Pat, Kristina, and Jacki from my previous cohort for your support and kind words when things were difficult.

Thanks to the staff at Capital Academy, who helped provide the groundwork as a clinician and leader today.

Thanks to my friends who have picked me up when I was down and held me up when I was having difficulty.

Thanks to Jennifer Caso, the person with whom I rode out my last two years and who has been such a good support and coworker.

Thanks to Lorissa Luciani. Not only have I taken this journey to become a psychologist, but at the same time we have grown as co-parents of the best child anyone could ask for.

Thank you for your support during this.

And lastly, thanks to my parents and sister, who have been supportive when things were great and things were difficult. They have taught me the true meaning of unconditional love and support.

Abstract

In 2003, the New Freedom Commission on Mental Health articulated a call for mental-health-care service systems to transform their service systems to a recovery-oriented model. Current research regarding the integration of recovery-based services has predominantly been conducted in outpatient and community provider settings (Crane-Ross, Lutz & Roth, 2006; Deegan et al., 2008; Matthias et al., 2012; Salyers & Tsemmeris, 2007; Solomon & Stanhope, 2004). The following study examines whether adult inpatients with serious mental illnesses perceive their treatment to meet recovery-related standards at a private psychiatric hospital that uses a recovery-oriented treatment system. The study will further identify if there is a relationship between patient perception of adherence to recovery-informed practices and participation in therapeutic services, the administration of medication (PRN), level of family involvement, interaction with peer specialists, the level of perceived self-stigma, and the perception of shared decision-making. The sample consisted of patients discharging from Friend's Hospital. Data were collected from 70 adult participants who were discharging from Friends Hospital. The current study used a correlational analysis to examine the relationship between scores on the dependent variables scores for both the Clinical Decision-Making Style scale and the Self-Stigma of Mental Illness Scale- Short Form, number of notes regarding family contact, number of PRN medications administered, and amount of time spent with peer specialists and the dependent variable scores on the Recovery Self-Assessment scale. A MANOVA test was used to determine if there was a difference in means between patients who were admitted voluntarily versus involuntarily and scores on the Recovery Self-Assessment scale, the Clinical Decision-Making Style scale, and the Self-Stigma of

Mental Illness Scale-Short Form. A multiple regression was conducted to determine the relationship between scores on the Recovery Self-Assessment scale and the Self-Stigma of Mental Illness Scale-Short Form and the Clinical Decision-Making Style scale. Results concluded that there were significant relationships between scores on the Recovery Self-Assessment scale, client rating of their perception of inclusion in decision-making, and level of self-stigma. Limitations of the study were that some variables were difficult to measure. Future research may want to further revise how inpatient treatment providers can employ strategies to encourage patient participation in decision-making and to lower self-stigma.

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Chapter 1: Introduction

Statement of the Problem

Mental-health providers, researchers, consumer advocates, and policy makers continue to develop strategies to improve the quality of psychiatric services. One pivotal and far-reaching development that has changed the nature and delivery of psychological services is the recovery movement. The recovery movement identified that services should be implemented to be patient centered, foster empowerment, include the patient in treatment decisions, and use both peer and families to help provide treatment (Anthony, 1993; Deegan & Drake, 2006; Jacobson & Greenley, 2001). One of the goals of the recovery movement, which started to gain traction in the 1990s (Anthony, 2000), is to empower individuals with serious mental illnesses (SMIs)¹ to increase treatment participation and develop increased ownership in all aspects of their treatment planning. This stands in contrast to the more traditional model, in which individuals with SMI have little choice in or input regarding their own care decisions (Kelly & Gamble, 2005). The recovery model further suggests treatment should promote hope, risk taking, a person-centered orientation, and collaboration with cross-disciplinary professionals, and should occur in a nonlinear fashion (Cleary & Dowling, 2009; Ferderick, Staley, Kress, & Vogel-Scibilla, 2001). Simultaneously, the goal of treatment providers who are influenced by recovery-based principles is to assist patients to build on their strengths to cope with managing their psychiatric symptoms (Rusinova, Rogers, Ellison, & Lyass, 2011). One major event that supported these changes occurred when the recovery movement was endorsed in the President's New Freedom Commission report. This report called for a change from the medical model, which has dominated the mental-health service provision system in the United States for approximately the

¹Note that *individuals with serious mental illness*, *patient*, and *consumer* will be used interchangeably to identify participants in psychological services.

past 100 years, to a recovery orientation (Kihlstrom, 2002; New Freedom Commission on Mental Health, 2003). As a result, this has been hoped that providers would embrace and implement recovery-oriented services to individuals with SMIs, representing a shift from traditional models of treatment.

The recovery movement defines treatment success as an individual's ability to live a full life while adjusting to his or her psychiatric condition, rather than targeting a remission of symptoms and returning to baseline functioning (Anthony, 1993; Kelly & Gamble, 2005; Lloyd, Waghorn, & Williams, 2008). A recovery-oriented strategy supported to facilitate the achievement of these goals is the use of peer supports or peer specialists, who are individuals who have had their own experience with mental illnesses and are in the process of their own recovery (Cunningham, Wolbert, Graziano, & Slocum, 2005; Moran, Russinova, & Stepsas, 2012). Peer specialists are regarded as an essential component of recovery-oriented service environments and are increasingly hired to provide support that augments the work of traditional mental-health providers. A recovery-oriented service system further espouses clinical processes, such as shared decision-making, when discussing treatment and service empowerment (Crane-Ross, Lutz, & Roth, 2006; Deegan, Rapp, Holter, & Riefer, 2008). This process refers to patients sharing their own goals and wishes and collaborating as partners with medical professionals when deciding on interventions strategies and treatments to cope with their psychiatric symptoms (Drake, Deegan, & Rapp, 2010; Joosten et al., 2008). Interventions that have an empowerment focus, such as shared decision-making, invite the consumers to participate in decisions about treatment with the same level of reciprocity and respect that is given to their service providers (Crane-Ross et al., 2006). Service empowerment utilizing shared decision-making can be an effective strategy that embodies recovery principles by endorsing the value of choice and

autonomy and invites consumers to participate in the decision of whether or not to take medication and engage in psychotherapy and other supportive services (Crane-Ross et al., 2006; Deegan et al., 2008; Drake et al., 2010). In addition to building a collaborative environment between mental-health consumers and providers, the recovery paradigm enhances the quality of consumer care by encouraging self-management, refocusing on strengthening the therapeutic alliance, promoting holistic wellness, increasing community participation, creating social supports, and providing consumers with knowledge and skills that can help them relieve psychiatric symptoms (Chang, Alley, Tamar, & Chen, 2013; Drake et al., 2010; Lloyd et al., 2008; Moran et al., 2012). Lastly, the recovery movement advocates education for the general public to understand the true nature of mental illness as a means to deter both public stigma and patients' self-stigma (Anthony, 2000; New Freedom Commission on Mental Health, 2003). Overall, the goal of recovery-based services is to transform the current delivery system to become person centered and collaborative and to provide education regarding the public perception of SMIs, while empowering consumers to take more of a lead in their treatment and decrease possible self-stigmatizing beliefs about their limitations (Anthony, 2000; Crane-Ross et al., 2006; Frese et al., 2001; Matthias, Salyers, Rollins, & Frankel, 2012; New Freedom Commission on Mental Health, 2003).

To identify the progress of mental-health systems and professionals in their success in changing the delivery of psychiatric services, Anthony (2000) recommended that participating providers and researchers assess whether their treatment protocols are based in recovery-based principles. The author recommended that providers measure the extent to which patients are experiencing services as being recovery based with the use of such assessments as the Recovery Self-Assessment (RSA) scale and/or the Recovery Process Inventory (Corrigan, Salzer, Ralph,

Sangster & Keck, 2004; Jerrell, Cousins & Roberts, 2006). Research to date has focused on measuring the perception of outpatients and community providers, with few studies considering providers in in-patient psychiatric hospitals who have also begun to transition to recovery-oriented care models (Crane-Ross et al., 2006; Deegan et al., 2008; Matthias et al., 2012; Salyers, Tsi & Shultz, 2007; Solomon & Stanhope, 2004).

Purpose of the Study

In 2003, the New Freedom Commission on Mental Health articulated a call for mental-health-care service systems to transform themselves to a recovery-oriented model. Many states and their service providers have done so by changing their mission statement, providing recovery-oriented trainings, providing consumer-based services, and linking up patients with adequate housing, employment, and education possibilities (Sowers, 2005). In addition to providing further recovery-oriented services, programs were tasked to assist patients to build on their strengths to cope with and manage their psychiatric symptoms (Rusinova et al., 2011).

Current research regarding the integration of recovery-based services has been conducted predominantly in outpatient and community-provider settings (Crane-Ross et al., 2006; Deegan et al., 2008; Matthias et al., 2012; Salyers, 2007; Solomon & Stanhope, 2004). The following study examines if adult inpatients with SMIs perceive their treatment to meet recovery-related standards at psychiatric hospitals that use a recovery-oriented treatment system. The study will further identify if a relationship exists between patient perception of adherence to recovery-informed practices and participation in therapeutic services, the administration of psychiatric medication (PRN), level of family involvement, interaction with peer specialists, the level of perceived self-stigma, and the perception of shared decision-making.

Chapter 2: Review of the Literature

The Recovery Movement

The recovery movement has superseded the medical model as the preferred framework for providing mental-health services in the United States (Kelly & Gamble, 2005). Recovery-oriented services are designed to be patient centered and to focus on empowerment, collaborative decision-making, fostering hope, and utilization of peer services (Anthony, 1993; Deegan & Drake, 2006; Jacobson & Greenley, 2001). The origin of the recovery movement resulted from advocacy by consumers, practitioners, and supporters to empower patients to increase control over their own decisions about mental-health care. Advocates of the recovery model promote the idea that patients should be empowered to have an active role in their services while service providers assist them to foster hope and their ability to lead active and productive lives while managing their symptoms or gaining a full recovery (Ferderick, Staley, Kress & Vogel-Scibilla, 2001).

The recovery model is a multidimensional patient-centered framework that currently guides the treatment and conceptualization of psychiatric illnesses (New Freedom Commission on Mental Health, 2003; Substance Abuse and Mental Health Services Administration [SAMHSA], 2005). Anthony (1993) described the concept of recovery as a deeply personal and unique process during which patients change their attitudes, values, feelings, goals, and skills and move away from perceiving themselves and being defined in a patient role. Anthony's definition characterizes recovery from psychiatric illness as a path on which individuals and treatment providers challenge their attitudes and beliefs about the limitations that have

historically been associated with SMI. Other researchers and consumers have defined recovery as the lived or real-life experience of people as they accept and overcome the challenges of their psychiatric disability and experience themselves with a new purpose and sense of identity (Deegan, 1988). Therefore, consumers and providers are challenged to change how the perception of the severity of psychiatric illness affects individuals, with the goal of working toward refocusing on their abilities and strengths. Finally, the recovery model encourages patients to redefine how to manage their psychiatric symptoms, with the goal of living meaningful lives and having the opportunity to make valuable contributions to society (Anthony, 1993; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). Overall, the goal of recovery is for patients not only to cope with psychiatric symptoms, but also to adapt and thrive without having their disability define their capability to engage in a meaningful life. The challenge that administrators, policy makers, and practitioners face is how to adjust their current service structure to provide recovery-oriented treatment.

The History of the Recovery Movement

The recovery movement is considered to have evolved out of several other historical movements that laid the groundwork for the current recovery paradigm. The recovery movement of the 1980s and 1990s came about largely from efforts of individuals diagnosed with mental illnesses themselves (Anthony, 1993). However, these grassroots efforts were aided and supported by several mental-health professionals and pivotal historical events.

One of these professionals was Abraham Low, a physician who began to use recovery-based principles to treat patients in the 1940s (McCranie, 2011; Sowers, 2005). Dr. Low's strategies, such as avoiding relapse through social-skill development, mirrors recovery-based principles by promoting patient empowerment and using structured self-help groups, in addition

to formal psychiatric treatment (McCranie, 2011). Ahead of their time, Dr. Low's concepts did not become accepted in the delivery of psychiatric treatment for several decades.

The first group that advocated for a fundamental change in psychiatric services was the consumer-survivor movement. R.D. Laing and Thomas Szaz, both leaders of the antipsychiatry movement, championed the consumer-survivor movement of the 1950s to 1970s (Frese & Davis, 1997; Tomes, 2006). This movement was supported by left-wing organizations that also took a public position, with the goal of visibly advocating for themselves (Rissemiller & Rissemiller, 2006). The consumer-survivor movement started when ex-patients who felt victimized by the psychiatric system demanded the general public to recognize their suppression, change policies regarding institutionalization, provide new effective psychotropic pharmaceuticals, and identify and strengthen the legal rights of patients (Jacobson & Curtis, 2000; Tomes, 2006). Patients advocated for protection from practitioners who used coercive treatments and high doses of neuroleptics and performed psychosurgical procedures (Rissemiller & Rissemiller, 2006). In addition to demanding new treatments and changes in provider attitudes and practices, these patients began to fight to ensure they had the same rights as individuals suffering from physical disabilities. The consumer-survivor movement has been described as the response of patients who felt they were victims of civil-rights violations (Bassman, 1997). The consumer-survivor/ex-patient movement rallied to make political changes to the psychiatric system to prevent anyone from having to suffer humiliating and ineffective treatments. Despite these early efforts, practitioners and policy makers took decades to change the delivery of services to adequately meet the standards demanded by the consumer-survivor movement.

The consumer-survivor movement was also a direct outgrowth of the civil-rights movement, which was a pivotal historical event in the evolution of the recovery paradigm

(Anthony, 1993). Civil rights were also discussed and litigated for individuals confined in psychiatric institutions, which led to the era of deinstitutionalization of the 1960s and 1970s, when patients were discharged from state-run inpatient psychiatric hospitals into the community in large numbers (Anthony, 1993). Individuals returned to their communities with the goal of becoming autonomous and thriving in the least restrictive environment. To ensure that patients remained autonomous, providers had to meet the unique needs of those discharged into the community by providing external resources, such as case management (Anthony, 1993). These developments laid the groundwork for the recovery movement, as patients' independence and integration into the community were promoted.

New research findings also challenged and changed the conceptualization of SMIs. Previous beliefs about SMIs entailed pessimistic prognoses and projected limitations such that patients would never thrive after being diagnosed with a serious psychiatric illness. However, one ground-breaking European longitudinal study followed released state-hospital patients for an average of 37 years (Ciompi, 1980). Focusing only on individuals diagnosed with schizophrenia, the author concluded that the majority of individuals not only had better life expectancies, but also had a more variable and positive long-term prognosis than previously believed. Harrison et al. (2001) later completed a survey of patients diagnosed with schizophrenia at 15 and 25 years post release. These researchers also found that greater than half of the participants were gainfully employed and obtained ratings above a 60 on the Global Assessment Functioning scale. Greater than 50% of participants interviewed at the 2-year follow-up time point reported they had not experienced a psychotic episode and met the criteria for having recovered on the Bleuler scale (Harrison et al., 2001). These studies confirmed that half of the individuals who once experienced or were still experiencing serious psychiatric symptoms could thrive and live full

lives. This finding stood in contrast with long-held beliefs that SMI has a chronic unremitting course and that most patients only would be able to manage their illnesses without being able to return to and fully engage in their communities.

The large-scale adoption of the recovery paradigm ultimately came about because of the report from the New Freedom Commission on Mental Health Services (New Freedom Commission on Mental Health, 2003; Solomon & Stanhope, 2004). The Field Commission report was developed under the directive of President George W. Bush in 2002 in order to identify effective strategies to improve the delivery of psychiatric services (Solomon & Stanhope, 2004). This landmark document highlighted the need for a shift of the delivery of mental-health services from the medical model to a consumer-driven recovery paradigm. The report made recommendations regarding strategies to provide mental-health services that reflect patient-centered strategies, as well as the inclusion of family values and use peer supports (New Freedom Commission on Mental Health, 2003). This document stipulated psychiatric treatment providers to recognize the ability of patients to recover, the articulated role and impact of stigma on patients and the community, and the reinforced value of building resilience (New Freedom Commission on Mental Health, 2003). The New Freedom Commission report changed the framework for psychiatric services delivery and provided guidelines for practitioners and policy makers to make administrative adjustments in their orientations to provide patient-centered, recovery-oriented treatments.

The Recovery Paradigm

Before the recovery movement became the guiding model for mental-health care, the delivery of psychiatric services followed the medical model (Bellack, 2006; Kelly & Gamble, 2005; Solomon & Stanhope, 2004). In the medical-model tradition, patients are regarded as

passive recipients of treatment and are expected to follow the recommendations of the prescribing practitioner (Kelly & Gamble, 2005). The patient's role in this paradigm is to follow the practitioner's advice without having any significant input into treatment decisions. Practitioners practicing from a strictly medical model address psychiatric illnesses by focusing on treatment management and symptom reduction (Solomon & Stanhope, 2004). "Getting better" was operationalized as returning to one's baseline functioning as compared to one's life before experiencing a specific disorder (Bellack, 2006 Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). The providers who subscribe to this model often neglect to address and consider other lifestyle issues and resource deficits, such as housing and employment, that may impact a person's mental health.

In contrast, the recovery-oriented paradigm has a different conceptualization about the treatment of psychiatric issues. Davidson et al. (2005) gave an example of recovery "in" mental illness by comparing SMI to a chronic medical condition, such as asthma, for which no end cure exists, yet patients can manage their illness by making specific lifestyle changes. Therefore, following this line of reasoning, recovery can occur without a complete remission of psychiatric symptoms, and patients can still live full lives (Anthony, 1993). Patients in recovery adjust their perception from hopelessness to empowerment while learning to adapt to their psychiatric symptoms. Therefore, recovery from mental illness is not linear, as some patients may never fully experience relief from their psychiatric symptoms and will have to make adjustments in response to perceived setbacks (Anthony, 1993; Cleary & Dowling, 2009; Deegan, 1988). The challenge that administrators and policy makers who are committed to recovery-informed care continue to face is how to best change traditional service provision models to those that utilize recovery-based conceptualizations and treatment of mental illness. Additionally, such providers

need to be aware of how clients are responding to recovery oriented strategies and address whether they have been successful in changing the culture of their treatment center.

Recovery-Oriented Psychiatric Services

The report by the New Freedom Commission on Mental Health (2003) provided a framework for recovery-oriented service delivery. It stated that recovery-oriented services and treatments must be consumer and family centered, increase the consumer's ability to successfully cope with life's challenges, and build on resilience. It further suggested that individuals who receive recovery-oriented services must have a choice about which mental-health professional team they want to work with, must be involved in shared decision-making, and should have the option to agree or disagree with their treatment plan. The New Freedom Commission on Mental Health report consists of six major overall goals for providers to include in their service environment: to reduce stigma, ensure that treatment is patient and family driven, ensure everyone has access to quality care, encourage medical and mental-health professionals to become proactive to identify clinical issues, promote research, and use technology to ensure accurate communication is used among practitioners. This report identified the goals of the recovery model while ensuring a person-centered approach that includes outside resources and strategies that practitioners and policy makers can employ to provide effective treatment in all service environments (New Freedom Commission on Mental Health, 2003)..

After the New Freedom Commission report was released, providers who adhered to these guidelines recognized that they had to make changes in policies and clinical procedures to provide recovery-oriented services in all treatment environments. Many of the changes made were both administrative and philosophy oriented. One change suggested to administrators was to incorporate the language of recovery into the provider's mission statement (Anthony, 2000).

Recovery-oriented practitioners were asked to ensure that they provided strength-based services, encouraged individuality, and helped promote accurate positive portrayals of what experiencing a mental illness means (O'Connell, Tondora, Croog, Evans, & Davidson, 2005). Recovery-oriented care stipulates that mental-health professionals promote and empower patients' active participation in their treatment, in addition to using language promoting hope and change for a better quality of life with increased self-determination (Gagne, White, & Anthony, 2007). Researchers suggested that after their implementation of changes in service provision and mission statements, providers use empirical outcome assessments to measure if their patients have perceived those services as being recovery oriented (Anthony, 2000). Using tools to measure patient perception gives practitioners feedback that can help them to identify when and where to make necessary adjustments in their service environment.

Russinova et al. (2011) completed a study that surveyed patients, practitioners, and peer support specialists to examine what they perceived to be necessary for recovery-oriented environments. They found that practitioners who were perceived as person centered and as valuing the importance of the patient-client relationship were the most influential agents of change when providing recovery-based services. They also found that providers' capacity to enhance patient skills was a barometer of recovery perceptions (Russinova et al., 2011). Practitioners can work with patients by teaching coping skills and providing referrals to community-based services. Finally, practitioner availability was found to be strongly related to what participants thought a recovery-oriented service system should look like (Russinova et al., 2011). Patients seemed to benefit when clinicians and psychiatric support were available and when delay in receiving assistance was minimal once the need was recognized.

Advocating for stigma reduction and requesting appropriate treatment funding have also been a part of practicing in a recovery-oriented environment (Anthony, 2000; Corrigan, 2004). Practitioners have been encouraged to advocate for research funding to discover the most effective ways to implement recovery-oriented services and how to best deliver empirically supported treatments within community service environments. Practitioners have also been encouraged to use their education and skill sets to inform the community about SMIs in order to correct many of the misperceptions that people may have. Mental-health professionals who use the recovery model should have knowledge about at least several treatment options that they can present to their patients and should use shared decision-making in the treatment selection process (O'Connell et al., 2005). Having more than one treatment option allows patients to choose the best treatment for themselves and to empower themselves to make choices that have been found to improve their satisfaction with treatment (Duncan, Best, & Hagen, 2010). Lastly, practitioners have been encouraged to guarantee that services provided are culturally relevant for all patients to enhance treatment outcomes (Anthony, 2000). In order to provide relevant services that are congruent for patients in this context, practitioners must understand how their patient's culture may affect his or her perceptions of treatment. Recovery-oriented services are provided to clients based on their unique values and culture. Clinicians that are culturally sensitive reflect an understanding of how consumers' values and beliefs may affect their role in treatment, their goals, and what their perception of a meaningful life might be. Overall, in order for psychiatric treatment to meet the needs of consumers and truly embrace recovery-oriented care, service environments need to make programmatic and clinical changes. While recovery-oriented services have been implemented across the country, very few research studies have examined the impacts of these policy changes on relevant empirical outcomes (Bellack & Drapalski, 2012).

Living with Mental Illness: Dealing with Symptoms and Iatrogenic Experiences

People with psychiatric conditions often have to deal with several internal and external challenges that interfere with their quality of life (Anthony, 1993). Patients who live with SMIs have to cope with their psychiatric symptoms, as well as cope with the side effects or covariates of having such an illness, including stigmatization, poverty, and a lack of self-determination (Anthony, 1993). These external challenges impose barriers that must be addressed to assist patients to experience a satisfying life. Providers are advised to keep in mind that individuals may have had past adverse experiences acknowledging when they needed assistance (Davidson et al., 2005). Asking for help may be especially challenging when they are at risk of losing their freedom and receiving medical interventions they are not accustomed to, such as involuntary hospitalizations, psychotherapy, and constant observation by staff during their activities of daily living. Individuals who experience SMIs also struggle with frequent hospital readmission, impairment in functioning, and acclimation back into the community (Moran et al., 2012). With all of these challenges, individuals with SMIs sometimes find that recovering from the side effects of mental illness may be more difficult than managing the illness itself (Anthony, 1993). In order to cope with both the internal and external challenges that having a mental illness can encompass, people in recovery advocate for decreasing the stigma of having a SMI by promoting equal opportunities, as well as basic human rights, such as access to medical care, employment, shelter, and food (Jacobson & Greenley, 2001). Therefore, the recovery paradigm addresses not only the symptoms of a psychiatric diagnosis, but also the debilitating side effects that influence a person's quality of life. It does so by providing such services as peer involvement, shared decision-making, promoting hope, and empowerment across life domains in all treatment

environments (Anthony, 1993; Duncan et al., 2010; New Freedom Commission on Mental Health, 2003; SAMHSA, 2005).

Conceptualizations of the Recovery Paradigm

Researchers and policy makers have conceptualized the recovery model in several ways. Jacobson and Greenley (2001) divided the experience of recovery into internal and external experiences. Internal conditions are patients' attitudes, experiences, and processes of change (Jacobson & Greenley, 2001). In other words, coping is influenced by the patient's perceptions and beliefs regarding his or her self-efficacy and potential to adjust to his or her mental illness.

One internal condition thought to be essential to recovery is hope. Hope is necessary for patients to become engaged in treatment and to believe that recovery is possible (Jacobson & Greenley, 2001). Hope seems to be especially important at the initial stage of recovery (Cleary & Dowling, 2009). Having hope may be a necessary component of motivation that enables individuals to take risks and make efforts to deal with their mental-health issues. Hope is also thought to be crucial to recovery, as it helps patients to accept that a problem exists, invest in change, celebrate with small goals, and focus on strengths (Jacobson & Greenley, 2001).

Another important internal condition thought to be necessary to recovery is empowerment. Empowerment has been defined in this context as individuals with SMI taking control of their lives by reducing reliance on practitioners and taking action on behalf of themselves (Dickerson, 1998). Empowerment changes the sense of helplessness a person may feel by building autonomy and self-confidence and assists individuals with making meaningful choices in their lives, as well as about their treatments (Jacobson & Greenley, 2001). Patients who feel empowered build self-efficacy and self-esteem by making significant decisions that have positive outcomes. Empowerment also increases autonomy, which can lead to a reduced

reliance on mental-health professionals for their well-being and encourages people to take action on their own behalf (Dickerson, 1998). Individuals who become empowered gain the mastery to rely on themselves and their chosen supports, instead of needing continued care from their treatment team. Dickerson (1998) identified empowered patients as individuals who build personal competence, accept their disability, and develop the efficacy to engage in making important decisions for themselves. Although empowerment is important, it is helpful only if patients have the courage to try new activities and step out of their routines (Jacobson & Greenley, 2001). Empowerment enables patients to become more involved in their treatment and encourages them to feel they can effectively make positive changes.

External conditions also influence practitioners and the delivery of recovery-oriented psychiatric services. External conditions are the events, policies, and practices that direct practitioners to adequately provide recovery-oriented services (Jacobson & Greenley, 2001). In order to make the adjustments suggested by the New Freedom Commission report, providers had to ensure that staff adapted to recovery-oriented treatment strategies (Anthony, 1993).

Administrators and policy makers have had to change their policies and modify their clinical procedures to provide recovery-based services. Practitioners promoting recovery must expand services to address self-esteem, adjustment to disability, empowerment, and self-determination (Anthony, 1993; Russinova et al., 2011; SAMHSA, 2005). In addition to treating the symptoms of mental illness, recovery-based services need to account for internal challenges that had not been prioritized by clinicians in the past.

Providers in a recovery-informed context need to communicate to their patients that they believe recovery is possible by actively encouraging them to take steps toward their goals. Providers further need to support an environment where clinicians are characterized as people

who are trustworthy, empathetic, compassionate, and respectful and who celebrate diversity (Anthony, 1993; Jacobson & Greenley, 2001). Recovery-informed environments employ mental-health professionals who use person-centered approaches and value the relationships and perspectives of their patients. Collaboration between patients and the providers is another external condition that promotes recovery-oriented principles. Providers promote empowerment and trust by collaborating with and encouraging a positive interpersonal relationship with their patients (Cleary & Dowling, 2009).

Lastly, providers empower patients by encouraging them to safely take chances with new opportunities in life and by reminding them they have the right to make mistakes without being blamed for their illness or unnecessarily restricted in the future (Cleary & Dowling, 2009). Risk-taking acknowledges the consumer's choice and autonomy (Cleary & Dowling, 2009). Helping patients engage in new activities is important to recognize, as patients may have previously been discouraged to take risks in order to avoid possible failure. Encouraging patients to take some risks conveys trust and the belief that patients can be successful. It also communicates that a patient may not need to be protected and aids patients in feeling confident that they will not lose provider support if they attempt to grow and take chances.

In addition to providing recovery-based services, practitioners who identify as being recovery-informed in their practices must provide interventions that focus on symptom relief and crisis intervention (Jacobson & Greenley, 2001). These services, along with formal treatment, help patients progress outside of therapy, ensure safety, and assist with reintegration into the community.

The Substance Abuse and Mental Health Services Administration (SAMHSA; 2005) identified 10 key recovery principles in order to elucidate and operationalize the construct .

These points overlap with other conceptualizations in that they advocate that patients-consumers direct choices and decisions regarding their treatment, including an increased emphasis on the following: personal responsibility for their own care; individualized, strength-based, and person-centered treatments; empowerment; an expansion of treatment focus to holistic mind-body interventions; a nonlinear recovery trajectory; peer support; respect; and hope for the future (SMAHSA, 2005). These simple and clear-cut recommendations guide treatment providers to deliver recovery-based services.

Shared Decision-Making

One of the most significant changes advocated for in the recovery paradigm is the role and inclusion of patients in decision-making. This emphasis is characterized by a process during which the physician and patient collaborate to consider available information about medical conditions, including the options available, and then make a treatment decision that is congruent with the patient's conceptualization of health (Frosch & Kaplan, 1999). Shared decision-making was initially designed for physical health-care settings. Previously, the role of patients in both the medical and behavioral health fields was largely to be defined by passivity as recipients of treatment (Duncan et al., 20010. In contrast, the shared decision-making model assumes that the patient also has expertise. This strategy results in collaborative decisions that are made by practitioners and patients within their respective domains of expertise (Charles, Gafini, & Whelan, 1997; Deegan & Drake, 2006). This shift in power makes treatment decisions equally distributed between patients and providers. In practice, shared decision-making often looks like an interaction and discussion between both parties to identify the most effective treatment option available (Duncan et al., 20010. This process is active in that the practitioner and patient respect each other's input, with the goal of coming to a mutually agreed upon plan of treatment. Shared

decision-making in the behavioral health field is also rooted in the recovery model and emphasizes empowerment, as it encourages patients to take an active role in their treatment. Although different models are available for decision-making related to treatment, most patients with SMIs prefer shared decision-making about their mental-health care (Adams, Drake, & Wolford, 2007).

However, shared decision-making encompasses more than patients and practitioners talking about treatment options. Guidelines have been developed to help practitioners move toward implementing this new practice model. Practitioners who embrace shared decision-making are also encouraged to discuss patients' worries, fears, and expectations of treatment (Charles et al., 1997). Clinicians actively inquire about clients' potential concerns and ensure individuals' expectations of treatment are realistic and accurate. Practitioners are also directed to inform patients of all available treatment options (Charles et al., 1997), including aids that assist patients in the decision-making process (Patel, Bakken, & Ruland, 2008). An example of this type of aid are worksheets or cue cards including information regarding clinical procedures that is explained in general nonclinical terms so patients can better understand the material presented to them. The mental-health professionals inform consumers of available treatment options, including those that are available from other providers. Furthermore, the practitioners are advised to ensure that patients fully understand their treatment options and to confirm that patients are satisfied with their decisions (Charles et al., 1997). Throughout this process, practitioners should inquire if patients have any questions, check to see that they understand the nature of treatments available, and ensure that they are satisfied with their decisions. In summary, shared decision-making is an active process during which practitioners encourage patients to participate in

making choices about their treatment while ensuring that the patients' needs and concerns are met.

Research has identified several benefits of the shared decision-making model. One of the benefits of this strategy is that it helps bridge the use of empirically related treatments that are used with a specific population while taking concerns, values, and the personal context of the patients into account (Deegan & Drake, 2006). Shared decision-making ensures that patients choose a treatment that is relevant, meets their unique needs, and is congruent with what they are willing to engage in. This intervention ensures treatment is appropriate, and most patients who experience SMIs have been found to prefer shared decision-making approaches (Adams et al., 2007). A Cochran review study examined the effectiveness of shared decision-making and concluded that participants wanted more involvement in their treatment, but interestingly, the review did not find any significant effects on clinical or health outcomes regarding increase in patient treatment adherence or symptom alleviation (Duncan et al., 2010). The authors identified several possible reasons for the lack of distinct clinical outcomes. One reason suggested was that discrete patient encounters that utilized shared decision-making in a research study were inadequate to effect significant changes in patient outcomes. The authors thought that patients who have had several admissions to hospitals may struggle to trust mental-health professionals and may need to experience shared decision-making considerably more often before any change in outcomes could potentially be observed (Duncan et al., 2010). One should note that the Cochran study looked at only two studies, one of which did not account for sequence generation, such as when patients were surveyed only post intervention and when participants, providers, and outcome assessors were not blinded (Duncan et al., 2010). The medical research echoes similar results regarding shared decision-making. Medical studies have also found no measurable

improvement in clinical outcomes when physicians employed shared decision-making; however, medical patients also reported a better relationship with their physician with a preference toward this treatment strategy (Bieber et al., 2006; Edwards et al., 2004; Mandelblatt, Salyers, Rollins, & Frankel, 2006).

Therefore, both disciplines acknowledge that patients have a preference for shared decision-making, but currently little evidence exists for the efficacy of this strategy on patients' improvement of mental and physical health. Outcomes research on shared decision-making is still in the early stages, and more research needs to be conducted in the medical and mental-health communities to evaluate if it has tangible benefits other than patient satisfaction.

Peer Supports

An important service suggested by the recovery paradigm is the use of peer supports or peer specialists. Peer specialists are individuals who are in recovery from mental illnesses and who provide help to others who are still attempting to cope more acutely with similar issues (Bradstreet, et al, 2006; Daniels, Bergson, Fricks, Asheden, & Powell, 2012). Peer support is designed to provide personal insight and empathy to others dealing with similar problems, as the peer specialist has likely experienced them him or herself in the past. This interaction is generally informal and is provided by friends and acquaintances who have had similar experiences with psychiatric issues (Bradstreet, 2006). Peers provide several self-help activities or services that are available in the community (Solomon, 2004). One self-help activity is groups facilitated by peers, known as self-help groups (Salzer, Schwenk, & Brusilovskiy, 2010; Solomon, 2004). Peer-run groups address several issues, including how to best manage one's mental health, and consist of sharing experiences regarding having a mental illness and providing education and supports. Research has shown that peers who have experienced SMI are

potentially able to provide a subjective understanding about the difficulties that occur with managing psychiatric symptoms and the many associated difficulties that another person with an SMI might be experiencing (Daniels et al., 2012; Solomon, 2004). People who have mental-health problems may benefit when they work with peer supports who provide relevant advice based on their lived experience (Moran et al., 2012).

Certified peer specialists differ from general peer supports in that they are employed to provide mental-health services. Certified peer specialists work to engage patients in services that are not intended to replace psychiatric treatment, but to complement it (Bradstreet, 2006). In order to achieve these tasks, certified peer specialists receive formal training on delivering peer-supported services (Bradstreet, 2006). These specialists work alongside other mental-health professionals with the same goal of helping patients in their recovery. These paraprofessionals spend a significant amount of time sharing their personal experiences while encouraging self-determination, personal responsibility, and work on health and wellness; helping facilitate contact with providers; and teaching individuals about their psychiatric illness (Salzer et al., 2010). Certified peer specialists recognize the internal and external experiences of recovery by encouraging autonomy, providing reasons for hope, and referring patients to services offered in the community. One of the tools used in the recovery model is the Wellness Recovery Action Plan (WRAP), which is administered by certified peer specialists in both inpatient and outpatient settings (Federici, 2013). Certified peer specialists help patients complete this tool, which helps with daily maintenance plans, strategies to identify and respond to psychiatric triggers, early warning signs of relapse, and development of a crisis plan (Copeland, 2001). Peer specialists work alongside professionals by facilitating recovery-oriented groups in all types of environments, including inpatient hospitals and residential facilities (Moran et al., 2012). Lastly,

certified peer specialists also receive positive benefits when working with others and enhance their own recovery (Salzer et al., 2010; Solomon, 2004). Therefore, by helping others, peer specialists also experience benefits.

The U.S. military is now using peer supports to help individuals returning from combat (Grenden et al., 2010; Williams, Bambara, & Turner, 2012). Along with certified peer specialists, the armed forces are utilizing peer supports as a means to help returning soldiers cope with the unique challenges that these individuals face specific to post deployment (Williams, Bambara et al., 2012). Specific issues, such as depression, suicidal ideation, and posttraumatic stress disorder, are experienced by individuals returning from combat who can be assisted by peers who have suffered and coped with similar experiences (Grenden et al., 2010). These peers are particularly helpful in several ways, including helping to navigate the health system, decreasing depressive symptoms, increasing hope, and helping cope with their own stigma they may be experiencing with returning post deployment (Grenden et al., 2010; Williams, Bambara et al., 2012). Peer supports share their past experiences to help individuals develop hope.

Research supports the notion that peer services are valuable and effective in assisting veterans returning post deployment (Eisen et al, 2015; Eisen et al 2012; Resnick & Rosenshack, 2008). Research shows that peer-run groups are just as effective as clinician-facilitated groups when treating clinical issues of soldiers post deployment (Eisen et al, 2012). One study observed the outcomes of peer- versus clinician-run groups and found that both conditions had positive outcomes, with little difference in improvement between them (Eisen et al, 2012). In addition, soldiers who do attend peer-support groups report that they feel empowered, function better, and have lower alcohol use (Resnick & Rosenshack 2008). Along with providing effective services, veterans who act as peer providers also benefit from interacting with retraining soldiers (Eisen et

al., 2015). Post-deployed soldiers who provide peer-related services report they enjoy their positions as peer providers, have improved mental health, and experience a better quality of life (Eisen et al., 2015). Therefore, peer services for returning veterans may be an effective means of treatment from which both the peer and the consumer benefit.

Family Involvement in Recovery

The recovery movement has strongly recommended that practitioners engage patients' families and other allies in their mental-health services (New Freedom Commission on Mental Health, 2003; SAMHSA, 2005). The involvement of families in recovery-oriented care can be empowering for these families and bolster services provided by recovery-oriented practitioners (Sowers, 2005). Patients may be more reinforced to engage in recovery-oriented treatments if they are supported by families and loved ones. This involvement helps patients by incorporating family principles, such as specific values and family customs, into the treatment plan (Sowers, 2005). Involvement of the family or of significant others can be an integral part of recovery-oriented services that assist patients to engage in a meaningful life.

When families and friends become empowered and participate in treatment, they can become powerful therapeutic allies for patients. To help families, practitioners provide them with knowledge and coping skills specific to the mental illness their family member has been experiencing (McFarlane, Dixon, Lukens, & Lucksted, 2003). One way practitioners can assist patients' families and allies is to provide them with psychoeducation. In order to be effective and ensure best practices, research has identified psychoeducational guidelines and strategies for sharing information with families (McFarlane et al., 2003). Psychoeducation provides supporters with information regarding symptoms and how they can support the patient better. The psychoeducational approach generally identifies that SMIs are partially remediated by

medication and family involvement (McFarlane et al., 2003). The goal of providing family interventions is to minimize the biological vulnerability, support medication adherence, discourage illicit substance use, and assist with problem-solving strategies (Glynn, Cohen, Dilxon, & Niv, 2006). This strategy is important in that even brief psychoeducation can improve family self-efficacy (Solomon, Draine, Mannion, & Meisel, 1996). Although there are several empirically supported family-oriented interventions, psychoeducation is one that supports recovery-based principles and involves outside supports in the treatment process.

Patients have been shown to benefit when families are involved in treatment. Brekke and Mathisen (1995) completed a study of family support and found that patients who live with their families had fewer incidents of victimization by members of the community and less substance abuse. Also, individuals with family support were more likely to be employed and live in independent housing (Evert, Harvey, Trauerr & Herrman, 2003). Clark (2001) found that patients who were receiving economic support and family engagement experienced greater improvement compared to those who did not. Another study found that families who participated in applied family management treatment had lower rejection attitudes toward patients and that the patients reported less stress (Mueser et al., 2001). Therefore, patients with family involvement have a higher likelihood of being able to participate in purposeful activities and experience a better quality of life. Overall, patients with SMI who receive recovery-oriented services are likely to benefit when their families are engaged in their treatment, and their families are willing to learn about mental illnesses, as well as how to best support their family member.

Self-Stigma

Patients diagnosed with SMIs may be judged negatively by the general public and are exposed to stigma. Stigma can be identified as the negative consequences of being labeled or

defined by a personal characteristic (Hayward & Bright, 1997). Stigma is caused by misinformation communicated to the general public by movies, newspapers, and television about people in their communities who have SMIs (Corrigan, 1998). The stigma generally associated with SMIs is that patients with SMIs are unpredictable and dangerous (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Patients struggle with this imposed identity that does not represent the majority of people with mental-health issues. Stigma affects patients by causing them to experience discomfort and anger, and they also may suffer from lack of employment, housing discrimination, lower income, and being subject to both verbal and physical aggression (Corrigan, 2004). Discrimination causes patients to experience added stressors while coping with their psychiatric symptoms. Stigma has many negative consequences that affect patients who experience SMIs, yet the most disheartening consequence is how it can affect the way patients perceive themselves.

In addition to being exposed to stigmatizing attitudes and beliefs held by the general public, patients who experience SMIs may also suffer from self-stigma. Self-stigma is the internalized psychological outcome when someone with a mental illness believes that people with mental illnesses are deficient (Bathje & Pryor, 2011). Patients therefore may perceive themselves as less than normal and may have lower expectations for themselves. Self-stigma is problematic, as it may hinder individuals who could benefit from psychological services from seeking treatment in order to avoid becoming publicly identified by reaching out to providers (Bathje & Pryor, 2011). Hence, people may not want to acknowledge that they are experiencing psychiatric symptoms, as doing so would infer that they are “crazy” and require special services.

Self-stigma also can have a negative effect on the quality of life of individuals who have mental-health problems. People who experience self-stigma are at risk of experiencing low self-

esteem (Bathje & Pryor, 2011; Link, Stuenkel, Neese-Todd, Asmussen, & Phelan, 2001). Low self-esteem may result from patients believing that people rightfully reject individuals with SMI (Link et al., 2001). Individuals who experience self-stigma may restrict their social contacts in order to avoid feeling that others are judging them (Bathje & Pryor, 2011; Link et al., 2001). Similarly, individuals feel the general public will reject people with mental-health issues; therefore, they may become reluctant to attain employment or engage in relationships (Link et al., 2001). Patients who experience self-stigma may have a lower quality of life, which, in turn, can have an adverse effect on their treatment. The recovery movement attempts to address patients' self-stigma by empowering them and their families to learn how to cope with psychiatric symptoms while engaging in a meaningful life.

The New Freedom Commission on Mental Health report identified that stigma regarding mental illness causes discrimination and hinders treatment engagement and, therefore, needs to be actively addressed (New Freedom Commission on Mental Health, 2003). Members of the general public who stigmatize people with SMI may treat others as defective, may be prejudiced against them, and, worse, may isolate from them. A goal of the recovery movement is to reduce stigma so the general public and practitioners will have a better understanding of the true nature of mental illness, dispute the myth that individuals with SMIs are dangerous, and reinforce the fact that people do recover (Anthony, 2000; New Freedom Commission on Mental Health, 2003). Practitioners who practice recovery-oriented services advocate for patients' rights and provide education to families, loved ones, and the general public. Researchers, Administrators and Practitioners thought and hoped that stigma reduction efforts will eventually result in treatment engagement with individuals who have been reluctant to seek care (New Freedom Commission on Mental Health, 2003). The idea is that if stigma is reduced, self-stigma may also

decline and patients will not be reluctant to address their psychiatric symptoms. In order to deal with stigma and mental illness, several groups, such as the National Alliance for Mental Health, have developed antistigma campaigns to educate the public and advocate for patients (Corrigan, 2004). Stigma reduction is an extremely important component of the recovery movement, for both the general population and health-care providers. Practitioners must examine their own beliefs about and stereotypes of patients, remain knowledgeable regarding advances in treatment, help promote hope to patients, and help society have an accurate understanding of the nature and course of mental illness.

Recovery Outcome Studies and Challenges

The recovery movement suggests clear changes in service delivery, with the goal of providing person-centered, recovery-oriented services (Anthony, 1993; Russinova et al., 2011; SAMHSA, 2005). Researchers and practitioners have also called for more research, the dissemination and access to empirically based treatments for individuals with SMIs, and measurement to determine if patients experience their services to be recovery oriented (New Freedom Commission on Mental Health, 2003; Reisner, 2005; SAMHSA, 2005). One of the main challenges ahead is for policy makers and practitioners to identify if patients actually improve as a result of practitioners delivering recovery-oriented services. The literature on the recovery movement is largely aspirational in nature and has focused on describing program models and dissemination; however, more recently, authors have called for research to focus on clinical outcomes and practices (Anthony, Rogers, & Farkas, 2003; Malinovsky et al., 2013).

Recovery-oriented services have been introduced to inpatient and outpatient settings. Inpatient hospitals have their own unique challenges regarding the delivery of recovery-oriented services, as patients are often admitted into these settings on an involuntary basis. Involuntary

admission, by definition, suggests that patients are unable or unwilling to take responsibility for their own treatment. Restriction of personal liberties and curtailment of choices are antithetical to the recovery movement. Additionally, inpatient environments are often highly structured and, therefore, may limit patient preferences regarding activities, including preferences towards a specific group therapy; rooming arrangements; and bedtime, shower, and lunch times.

Researchers and policy makers are challenged to develop strategies to deliver recovery-oriented services in environments that are less flexible and person centered and more restrictive in nature.

One study looked at rehospitalization before and after implementing recovery-oriented services in a behavioral-health organization. Malinovsky et al. (2013) found that patient rehospitalization declined 40% after providers changed their delivery of service to a recovery-oriented model. The behavioral-health organization implemented changes in policies, educated staff and patients, used peer supports, increased residents' responsibility, and incorporated recovery-oriented interventions into current services (Malinovsky et al., 2013). Although this new study is promising, there is a significant need for similar studies to examine if implementing recovery-oriented services has an effect on clinical outcomes, such as improved treatment adherence, gaining employment, improved perception of quality of life, improved follow-up with aftercare after an inpatient stay, increased utilization of community resources, reductions in level of self-stigma, and increased family involvement.

The following study will examine if Friends Hospital is providing services that patients experience to be consistent with recovery-oriented principles. The goal of this study is to identify if patients who perceive these services as recovery oriented also report that they are included in decisions regarding their treatment, have family contact, engage with peer support, have lower

reports regarding self-stigma, engage in treatment, and require fewer psychiatric PRN medications.

Chapter 3: Hypotheses

The study will use quantitative methods to identify if patients perceive the services provided by Friends Hospital to be recovery oriented. Several studies have identified the effectiveness of recovery-based services in outpatient facilities, yet little research has been completed to assess the impact and effectiveness of these approaches in inpatient facilities. Friends Hospital provides inpatient psychiatric services based on a recovery framework. The following study examines the extent to which patients in Friends Hospital perceive their treatment to be recovery-oriented.

Hypothesis 1

Patients who score high on the Recovery Self-Assessment scale will also score high on the Clinical Decision-Making Style scale, score lower on the Self-Stigma of Mental Illness Scale- Short-Form, have a higher attendance at regularly scheduled group sessions (measured by frequency), make more frequent contacts by telephone/visits/family session, have higher utilization of peer support services, and request fewer as-needed psychiatric (PRN) medications.

Hypothesis 2

Patients who are admitted on a 201 (voluntary) admission status will have higher scores on the Recovery Self-Assessment scale and the Clinical Decision-Making Style scale and lower scores on the Self-Stigma of Mental Illness Scale-Short-Form than patients who are admitted on a 302 (involuntary status).

Hypothesis 3

High scores on the Clinical Decision-Making Style scale and low scores on the Self-Stigma of Mental Illness Scale-Short Form will predict high scores on the Recovery Self-Assessment scale.

Chapter 4: Methods

Design and Design Justification

This study used a correlational, cross-sectional survey design with both primary and secondary data collection. It investigated if perceptions of shared decision-making, use of peer support, family involvement, use of psychiatric PRN medication, participation in treatment, and reports of self-stigma are predictive of study participants' perceptions of the treatment environment at Friends Hospital as being recovery oriented.

Participants

The participants in this study were adult psychiatric patients from an urban psychiatric hospital. All participants in this study were diagnosed by a psychiatrist with a psychiatric diagnosis and were admitted either voluntarily or involuntarily to an inpatient facility. Patients were excluded from potential study participation for the following reasons: younger than 18 or older than 60 years of age (0%); staying on the ward for less than 72 hours (0%); not fluent in English (13%); discharge to another inpatient hospital/inpatient substance abuse program, nursing home, jail, extended acute facility (0%); staying on the ward for longer than 45 days (0%); having intellectual disability, a pervasive developmental disorder, or psychiatric symptoms secondary to a medical illness or head injury (13%); meeting more than one exclusion criterion (0%); and other (1%; e.g., being in the hospital with a "fake identity"). A total of 70 of 72 patients, or 97 % of all admissions, met inclusion criteria. Participant selection was not random, and patients were selected out of convenience.

Inclusion Criteria

Patients eligible to participate in the study were required to be older than the age of 18 years and younger than the age of 65 years. Patients were also required to participate in treatment for a minimum of 3 days. Treatment for fewer than 3 days would likely not give a person a reasonable estimation to properly gauge an environment. Patients needed to be able to speak English and be available for a 20-minute interview. Participants also were identified by the authorized hospital personnel as being ready for discharge at the time that they consented to participate in the study. Participants were participants in treatment on the general adult inpatient units at Friends Hospital.

Exclusion Criteria

Participants excluded from the study were either younger than the age of 18 years or older than the age of 65 years. Participants were excluded if they could not understand English. Participants with intellectual disabilities, traumatic brain injury, or pervasive development disorder were not eligible for the study. Participants who were discharged to another psychiatric facility because of health complications or extended acute treatment needs were not considered. Patients were excluded if they had a maximum length of stay exceeding 45 days and remained in the hospital for more than 8 days following their research interview. Potentially eligible patients were approached as closely as possible to their discharge date. Patients who were currently pregnant were not eligible to participate.

Screening

Screening for possible eligibility for the following study was conducted by hospital staff. The investigator presented the study to the unit staff, including the psychology interns who managed their respective units. The principal investigator informed the interns of the inclusion

and exclusion criteria for the study. The interns had access to information to identify which patients met the criteria of the study. Upon agreement of the patient to speak to the principal investigator, the interns contacted the principal investigator with patient names and respective units where he confirmed their eligibility for the study.

Recruitment.

Patients who met the inclusion criteria of the study and agreed to talk with the principal investigator about possible research participation met briefly during the designated breakfast time in order not to interrupt treatment services. Participants then received information about the study, and if the person remained interested, informed consent was obtained for study participation. Participants eligible for the study then completed the surveys and the five short-answer questions. Patients who participated in the study received a 5-dollar gift card to a coffee shop for their participation.

Procedure

After completing all requirements to receive Institutional Review Board approval from both Philadelphia College of Osteopathic Medicine and Friends Hospital, the principal investigator scheduled a time to meet with the unit staff and psychology interns. A presentation about the study was provided during which unit staff and interns were able to learn the criteria for participation in the study during morning rounds. On the study start date, unit staff and/or psychology interns identified all individuals to be discharged with a 1- to 3-day time period. The principal investigator asked the patients if they would be willing to learn about a survey study to be conducted on the unit by a PCOM graduate student. Potential participants were told that the survey was about their experiences and perceptions of their hospital stay and that, if interested,

the researcher would be directed to contact them so they could receive more information about the study and decide if they wanted to participate. If a possible participant agreed, the principal investigator met with the patient during breakfast. At that time, the principal investigator introduced himself and offered the participant the chance to participate in the study, explaining the nature of the study and informing the person that he or she would receive a 5-dollar gift card to Dunkin Donuts for their participation and time. After the participant verbally agreed, the principal investigator obtained written informed consent. After the participant completed the informed consent document, the principal investigator administered the survey containing the various measures and scales.

After the participant completed the survey, the person signed a receipt for a gift card for Dunkin Donuts, which was given to the person at discharge with their other valuables. The principal investigator then reviewed the participant's chart and gathered data on patient participation and use of psychiatric PRN medication, recorded extent of family contact, and accessed the patient's satisfaction questionnaire.

Measures

Recovery Self-Assessment Scale

The Recovery Self-Assessment scale (RSA; O'Connell et al., 2005) is a 36-item, self-report measure used to identify if patients perceive that they are receiving recovery-based services. The RSA uses a Likert scale to allow participants to rate the recovery orientation of their treatment provider. The RSA has versions for consumers, clinicians, and support personnel; the current study utilized the consumer version. Answers are scored on a 5-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. The consumer version of the RSA assesses if psychiatric services provided facilitate the patient to feel that services are

recovery oriented related to that specific treatment environment. Sample questions include “Staff help me find jobs” and “Staff encourage me to take risks and try new things.” This scale has an alpha coefficient of .96 and an internal consistency of .76 to .90 (O’Connell et al., 2005; Williams et al., 2012). This instrument is also reported to have acceptable face validity (Campell-Orde, Chamberlin, Carpenter, & Leff, 2005).

Clinical Decision-Making Style Scale

The Clinical Decision-Making Style scale (CDMS; Puschner et al., 2013) is a 21-item, self-report measure that rates the patient perception of autonomy, decision-making preferences, and desire for information. The CDMS uses a Likert scale to allow participants to rate if they feel they are involved in the decision-making process when working with mental-health professionals. Answers are scored on a 5-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. The patient version of the CDMS was used in the current study to assess patient perception regarding involvement in decision-making, as well as style. Sample questions include “Important decisions should be made by the clinician in charge and not by me” and “I should make my own decisions concerning everyday problems connected to my illness.” Cronbach’s alpha ranged from .87 to .89. The authors reported that all indicators of reliability and validity for the clinical utility categories yielded results that are adequate for the chosen cut-off points (Puschner et al., 2013).

Self-Stigma of Mental Illness Scale-Short Form

The Self-Stigma of Mental Illness Scale-Short Form (SSMIS-SF; Corrigan et al., 2012) is a 20-item, self-report measure that rates patient self-stigma. The SSMIS-SF was developed to measure patients’ beliefs about mental illness with stereotype agreement, agreement, application, and harm to self (Corrigan et al., 2012). The SSMIS-SF uses a Likert scale to allow participants

to rate their perceived self-stigma. Answers are scored on a 9-point Likert scale ranging from “*I strongly disagree*” to “*I strongly agree*.” Sample questions include “Most persons with mental illness are to blame for their problems” and “Most persons with mental illness are dangerous.” Cronbach’s alpha ranged from .65 to .87 (Corrigan et al., 2012). The authors also reported that their scale had adequate validity, yet did not report their specific findings in their initial study.

Demographic and Clinical Variables Data Abstraction Form

Sociodemographic information was abstracted from each participant’s medical chart. Clinical information, such as diagnosis, legal admission status, psychiatric PRN administration during hospital stay, and length of time of hospitalization, was recorded verbatim from the study participant’s chart. Additionally, progress notes from psychology and social work were reviewed to identify frequency of contact with family members (treatment session and/or phone contact), as well as frequency of participation in therapeutic services offered at Friends Hospital.

Chapter 5: Results

Analytic Plan

The current study used a correlational analysis to examine the relationship between the following dependent variables: the Clinical Decision-Making Style scale (CDMS), the Self-Stigma of Mental Illness Scale-Short Form (SSMIS-SF), number of notes regarding family contact, number of PRN medications administered, and amount of time spent with peer specialist and the independent variable scores on the Recovery Self-Assessment scale (RSA). A MANOVA test was used to determine if there was a difference in mean scores on the RSA scale, the CDMS scale, and the SSMIS-SF between patients who were admitted voluntarily versus involuntarily. A multiple regression was conducted to determine if the scores on the SSMIS-SF and the CDMS scale can predict scores on the RSA scale.

Preliminary Analysis

Descriptive Statistics

Descriptive sample statistics are provided in Table 1. A total of 70 participants were recruited. These participants were admitted and discharged from two units at Friends Hospital in Philadelphia, Pennsylvania. Approximately 85 people were asked to participate in the study. On both units, the average number of discharges per day appeared to be from two to three. The principal investigator made approximately 35 visits to recruit, suggesting an estimated 210 participants were eligible for the study. Among the participants from two units, 62 were Philadelphia residents. Of the participants, 21 identified their racial identity as African American, 10 as Hispanic, 31 as Caucasian, and one as mixed. Three identified as “rather not say.” Of the 70 respondents, 41 identified their gender as male and 27 identified as female. Of

the 70 participants, two forms were not able to be included because of missing information. Of patients who were asked to participate in the study, 82% agreed to do so.

Table 1
Demographics of Participants

Characteristics	<i>N</i>	%
Philadelphia resident		
Yes	62	88.6
No	8	11.4
Employed		
Yes	16	22.9
No	53	75.7
Inpatient before		
Yes	50	71.4
No	20	28.6
How many times?		
Admin status		
201	55	78.6
302	14	20
Whose idea to go into the hospital?		
Family member	11	15.7
Partner	8	11.4
Professional responder	7	10
Self	70	100
Did you receive outpatient services before?		
Yes	40	57.1
No	30	42.9
Did you take psychiatric medication?		
Yes	50	71.4
No	20	28.6
What is your dx?		
Do you have substance abuse issues?		
Yes	43	61.4
No	27	38.6
Do you attend 12-step meetings?		
Yes	19	27.1
No	49	70.0
Do you engage with peers in		

the community?		
Yes	50	71.4
No	20	28.6
Did you find them helpful?		
Yes	51	72.9
No	20	28.6
How many times, if so?		
Did you engage with peers in the community?		
Yes	22	31.4
No	48	68.6
Did you find them helpful?		
Yes	20	28.6
No	3	4.3
n/a	47	67.1
Do you have a medical condition?		
Yes	33	47.1
No	37	52.9
What condition?		
Did you have family contact?		
Yes	53	75.7
No	17	24.3
Do you feel your family care will meet your needs?		
Yes	67	95.7
No	3	4.3
Race		
African American	21	30
Hispanic	10	14.3
Caucasian	31	44.3
Mixed	1	1.4
Rather not say	3	
Missing		
Gender		
Male	41	58.6
Female	27	38.6
Marital status		
Married	7	10
Single	46	65.7
Widowed	6	8.6
Divorced	6	8.6
Missing	4	5.7

Table 2
Descriptive Statistics

	<i>N</i>	Mean	Standard Deviation
Total RSA	70	128.9	28.5
Total CDMS	70	69.7429	15.1
Total SSMIS-SF	70	71.9571	32.97888

Note. RSA = Recovery Self-Assessment scale; CDMS = Clinical Decision-Making Style Scale; SSMIS-SF = Self-Stigma of Mental Illness Scale –Short Form.

Hypothesis 1.

A Pearson correlation was conducted to explore the nature of the relationship between scores on each measure, as well as between the RSAscale and the CDMS scale. Results confirmed that there was a significant positive correlation, $r = .275, p < .05$ (see table 3). This correlation suggests scores on the RSAscale were significantly related to scores on the CDMS scale.

A Pearson correlation was also conducted to identify a relationship between scores on the RSAscale and the SSMIS-SF. The results indicated a negative correlation, $r = -.265, p < .05$ (see table 3). These results suggest that patients who perceived that they had received recovery-based services also had a lower level of perceived self-stigma.

A Pearson correlation was also conducted to identify if there was a relationship between full and partial group attendance and scores on the RSAscale. There was no significant relationship between scores on the RSA and full or partial group attendance, $r = -.012, p > .05$, and $r = -.150, p = .112$, respectively (see table 3).

A Pearson correlation was conducted to identify if there was a relationship between the amount of recorded family contact and scores on the RSAscale. Results indicated that there was no significant relationship between amount of recorded family contact and scores on the RSA scale, $r = .75, p > .05$. Finally, a Pearson correlation was run in order to identify if there was a

relationship between the amount of psychiatric PRN medication provided and scores on the RSA scale. The relationship was not statistically significant, $r = .012, p > .05$ (see table 3).

Table 3

Hypothesis 1: Correlations with the Recovery Self-Assessment Scale

	Pearson correlation	Sig tail
CDMS	.275	.11
SSMIS	-.265	.013*
Full groups ^a	.302	.462
Paragroups ^b	-.150	.112
Family contact	.075	.272
PRN	.012	.463

Note. CDMS = Clinical Decision-Making Style scale; SSMIS-SF = Self-Stigma of Mental Illness Scale-Short Form.

Full groups= full group attendance^a. Paragroups= partial group attendance^b.

*Denotes significance at .05 level.

Hypothesis 2.

A MANOVA was conducted to examine the effect of the independent variable, admission status (i.e., 302 or 201), on scores on the RSA scale, the CDMS scale, and the SSMIS-SF. The assumption of equality of covariance was met as indicated by Box's test ($p = .053$). Results from the overall MANOVA were not statistically significant, $F(3, 65) = .137, p = .938$ (see table 4). This MANOVA indicated that admission status did not have an effect on participants' perceptions of recovery-based services, clinical decision-making, or self-stigma.

Table 4

Hypothesis 2: MANOVA Between Admission Status and Scores on Recovery-Oriented Measures

	201 ^a		302 ^b	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
CDMS	70.21	14.8	67.42	17.21
SSMIS-SF	71.5636	31.40580	74.6429	40.59103
RSA	128.6182	26.99622	126.7857	32.39226

^a201 = Voluntary admittance. ^b302 = Involuntary admittance. *Note.* CDMS = Clinical Decision-Making Style scale; SSMIS-SF = Self-Stigma of Mental Illness Scale –Short Form; RSA = Recovery Self-Assessment scale.

Hypothesis 3

A hierarchical multiple regression analysis was run in order to test if self-stigma and clinical decision-making, as measured by the SSMIS-SF and the CDMS scale, would significantly predict patient perception of recovery-based services.

Prior to running the analysis, assumptions of regression were tested. To determine if there was multicollinearity among any of the variables, correlation matrices were analyzed across all variables. Variance inflation factor and tolerance values were within acceptable ranges (.981 and 1.019, respectively), indicating that multicollinearity was not an issue with the data. Tests of skewness and kurtosis revealed that the variables were normally distributed. The assumption of independence was satisfied, as indicated by the Durbin Watson value of 1.774. Variables were also found to be homoscedastic.

As discussed in Chapter 2, Review of the Literature, stigma and self-stigma have been shown to impact clients suffering from SMI (New Freedom Commission on Mental Health, 2003). Therefore, scores on the SSMIS-SF were entered into the model first, followed by scores on the CDMS scale. This method permitted the principal investigator to determine the unique contribution of each independent variable to variation in perceptions of recovery-based services.

In Step 1 of the regression model, self-stigma significantly predicted perceptions of recovery-based services, $\beta = -.27$, $t(68) = -2.23$, $p = .026$. Self-stigma also explained a significant proportion of the variance in perception of recovery-based service scores, $R^2 = .070$, $F(1, 68) = 5.15$, $p = .026$. The Adjusted R^2 value decreased to .057, resulting in a shrinkage of

1.3%, meaning that the same model derived from the population would account for 1.3% less variance in the outcome (Field, 2013).

In Step 2 of the regression model, clinical decision-making significantly predicted perceptions of recovery-based services, $\beta = .24$, $t(67) = 2.114$, $p = .038$. With both independent variables included in the model, the Adjusted R^2 value increased to .128 ($p = .038$), or approximately 13%, meaning that clinical decision-making explained an additional 6% of the variance in perception of recovery-based service scores, indicating that the addition of clinical decision-making significantly improved the predictive value of the model, $\Delta R^2 = .058$, $F(1, 67) = 4.47$, $p = .038$ (see table 5). The Adjusted R^2 value decreased to .102, resulting in a shrinkage of 2.6%, which indicated that the same model derived from the general population would account for 2.6% less variance in the outcome (Field, 2013).

Table 5

Hypothesis 3: ANOVA to Identify the Predictability of Patient Perception of Recovery with Self-Stigma of Mental Illness and Inclusion with Clinical Decision-Making

	<i>B</i>	Std.Error	<i>B</i>	<i>T</i>	<i>p</i>
Constant	111.520	17.727		6.291	.000
Total CDMS	.454	.215	.243	2.114	.038
Total SSMIS-SF	-.198	.099	-.232	-2.012	.048

Note. CDMS = Clinical Decision-Making Style scale; SSMIS-SF = Self-Stigma of Mental Illness Scale-Short Form.

Chapter 6: Discussion

Friends Hospital is an urban, private, inpatient psychiatric facility that subscribes to the recovery model to treat patients who suffer from a variety of psychological conditions, including serious mental illness (SMI) and substance use and misuse. This study attempted to identify if patients' perceptions of recovery are influenced by the frequency of treatment attendance, the administration of psychiatric PRN medication, family engagement in services, interaction with peer supports, perception of inclusion in clinical decision-making, and perception of self-stigma regarding their mental-health condition. The principal investigator was anticipated that results from this study could help direct treatment and prioritize services in an inpatient hospital to ensure patients are receiving recovery-oriented services.

The recovery movement has emphasized freedom of choice and the importance of self-directed care by promoting the value that clients should be active members in their treatment team and be involved in the decision-making process (New Freedom Commission on Mental Health, 2003). Results from the study concluded that there was a positive relationship between patients perceiving that their services were recovery oriented and being an active participant when making clinical decisions related to their care. As discussed previously, shared decision-making is a collaborative process in which the patient and physician discuss and choose treatment options that fit the patient's idea of health (Frosch & Kaplan, 1999). This finding is congruent with the recovery model, as it takes into account the patient's values and is reported to be the preferred approach for how each patient experiences his or her illness (Adams et al., 2007 Deegan & Drake, 2006). The patients who participated in this study at Friends Hospital perceived their treatment to be recovery oriented, and they believed that they were active participants in the programmatic decision-making. Because these findings were correlational,

knowing whether the recovery orientation of the treatment milieu actually influenced or encouraged patients to be more active participants in their treatment choices or vice versa is impossible. However, one should note that these two factors were significantly related.

This study has important implications for treatment planning in the world of inpatient psychiatric treatment because self-directed care and active participation and responsibility for one's own care are important steps toward becoming autonomous. For too long in the history of inpatient treatment, patients have been sheltered away from society and have been deemed to be incapable of making their own choices. This societal attitude toward mental illness has assumed that patients with SMI do not have the capacity to make responsible choices in service of their own future, thereby encouraging dependency and passivity. The lack of choice has reinforced in these patients the message that they are not capable of independent functioning and functioning in their own communities as vital members of society, despite their symptoms. This stigma has contributed to a vicious cycle of removing patients from their communities, taking a top-down approach to mental-health care by reinforcing passivity and lack of independence, and then using patients' lack of autonomy as evidence that they are incapable of living independently in their communities.

While these results by no means suggest that simply because patients can make choices, they are making the very *best* choices, but they do suggest that when an inpatient setting embraces a recovery-oriented philosophy that values self-direction, patients *do* make their own choices, and choices and self-direction are important components of active decision-making and taking responsibility for oneself.

The New Freedom Commission Act identified that stigma regarding mental illness can hinder patients from seeking treatment (New Freedom Commission on Mental Health, 2003). This concept is important, as recovery-oriented services should hope to provide patients, and the general public, education regarding mental illness (Anthony, 2000; New Freedom Commission on Mental Health, 2003). Patients who are participating in recovery-oriented services would benefit from receiving education related to the nature of mental illness and from knowing that a growing body of evidence shows that people can and do recover and lead meaningful lives in their communities. This study confirmed that patients at Friends Hospital who perceived their treatment to be recovery oriented also had a lower perception of self-stigma.

People who experience both SMI and self-stigma may be at risk of suffering from low self-esteem and beliefs related to deficiency (Blythe & Pryor, 2011). Not only do they have to cope with their psychiatric illnesses, they also have to deal with believing that they are inferior to others; therefore, they may not engage with members of the community. An example could be individuals not applying for jobs or not believing that they would be good parents because of their mental illness. In addition, The New Freedom Commission on Mental Health (2003) points out that self-stigma deters patients from seeking mental-health treatment in order to avoid being identified. As a result of their fear of being identified as struggling from psychiatric conditions, individuals with SMI may avoid seeking treatment and, as a result, never learn that they can live a fulfilling life and recover.

The New Freedom Commission Act suggests that patients should have a choice in their mental-health treatment and should have input into their treatment plan (New Freedom Commission on Mental Health, 2003). In addition, Gagne et al. (2007) have suggested that patients should feel empowered and become active in their treatment. Patients at Friends

Hospital have a choice as to whether they want to participate in group therapy and which groups they wish to attend. In this sample, during an average length of stay of 15 days, an average of 14 full groups and six partial groups were attended. This study found that after comparing the two means with a *t* test, no relationship existed between scores on the Recovery Self-Assessment (RSA) scale and either full- or partial-group attendance. Therefore, although group participation is encouraged as part of the treatment at Friends Hospital, no statistically significant relationship between the patients' perception of receiving recovery-oriented services and group attendance was found. Voluntary group attendance remains an area for future investigation because group attendance rates may likely depend on multiple variables, not just choice alone. Such variables could include mood fluctuations; motivation; physical states, such as lack of sleep and hunger; and peer influences.

According to the research, providers that promote recovery-oriented services should include family participation as part of their treatment (New Freedom Commission on Mental Health, 2003; SAMHSA, 2009). Patients appear to improve as a result of their treatment for many reasons, including the provision of psychoeducation to families and giving information to support medication participation (Glynn et al., 2006; McFarlane et al., 2003). Unfortunately, results from this study identified no significant relationship between scores on the RSA scale and recorded family contact. Although family collaboration is important to include as part of a treatment plan, several factors, including brief lengths of stay, patients having difficulty with identifying contacts and their phone numbers, and patients refusing to include family members, may have obstructed Friends Hospital's social workers from making appropriate family contact.

Peer support is another important part of delivering recovery-oriented services. Although measured in the study, very few notes to report were logged in the charts; therefore, this variable was difficult to measure. Of the 70 subjects, 53 did not have notes identifying that they had peer contact. Therefore, whether or not perceived peer support actually was an important variable in effecting positive outcomes could not be assessed.

The study also attempted to identify if there was a relationship between scores on the RSAscale and the amount of as-needed, or psychiatric PRN, medication dispensed. The results of this study found no significant relationship between scores on the RSAscale and the amount of psychiatric PRN medication; although the study used measurement that better represents a participation of ingesting medication. Therefore, a conclusion cannot be drawn as to whether or not perceived recovery orientation actually influenced the number of times that patients in this study requested or were administered as-needed medication. In many cases, psychiatric PRN medication is dispensed either upon patient request or staff direction when patients do not believe that they are able to cope with disruptive mood states or challenging external demands in the environment. Revisiting this topic would be useful to determine more conclusively if patients who perceive that they are receiving recovery-oriented services actually make fewer requests or receive fewer prescriptions for extra medication. One might reasonably assume that in a recovery-oriented system of care, patients would have acquired enhanced abilities to cope with internal (mood) and external (environmental) challenges and that use of PRN medication would be a lower ranked choice or option compared to cognitive and behavioral strategies, such as personal problem-solving and use of peer support.

The study also attempted to identify if there was a relationship between admission status (voluntary vs. involuntary admission) and perception of receiving recovery-oriented services.

The New Freedom Commission Act suggests that patients should have a voice in deciding if they want to engage in treatment (New Freedom Commission on Mental Health, 2003). In this study, approximately 20% of patients were admitted involuntarily to Friends Hospital. The study attempted to identify if there was a relationship between admission status and scores on the RSA scale, the Clinical Decision-Making Style (CDMS) scale, and the Self-Stigma of Mental Illness Scale-Short Form (SSMIS-SF). Results found that that admission status had no effect on patients' perceptions of recovery-oriented services, perceptions of inclusion in decision-making, and reports on self-stigma . Again, this relationship would be interesting to explore in the future.

As stated earlier, there was a statistically significant relationship between scores on the RSA scale, the CDMSscale, and the SSMI-SF. Results identified that levels of self-stigma could predict scores on the RSA scale. In addition, scores from the CDMS scale actually did predict scores on the RSA scale. This finding seems to indicate that self-stigma significantly predicted the frequency of engagement in clinical services and that clinical decision-making also predicted perceptions of recovery-based services. The implications of these findings seem to suggest that when the inpatient milieu is designed to enhance patients' clinical decision-making and autonomy while reducing the frequency of communication that reinforces self-stigma, patients identify the environment as being more supportive of their recovery.

The recovery movement represents a significant deviation from more "traditional" models of inpatient treatment in which patients were viewed as dangerous individuals who needed to be removed from mainstream society and protected from themselves and their communities by being placed in asylums and/or locked facilities that communicated to them that they were not valued as equals to any other human beings and who were incapable of managing their own affairs and making informed choices about what happens to them in the future. In point of fact,

an unfortunate consequence of this paternalistic view of people with SMI has been to reinforce dependency and lack of autonomy, and then when patients with SMI struggle to cope in the “real world” of their communities, they are rehospitalized, only to be “taken care of” again or blamed for their inability to “make it” in the real world.

The New Freedom Commission report has laid out the groundwork for providing psychiatric services in a recovery-oriented manner (New Freedom Commission on Mental Health, 2003). In addition to recovery-oriented treatment, services should be provided taking into account a patient’s cultural beliefs and customs. One method to ensure that a patient’s culture is taken into account is to identify specific cultural beliefs related to mental illness. Identifying how a patient’s culture influences his or her perception of mental illness is important, as is providing psychoeducation and dealing with both stigma and the self-stigma that comes with experiencing psychiatric conditions. Understanding patients’ cultural influences and their perceptions of mental illness is important to ensure that education is provided in a culturally sensitive manner.

Along with accounting for patients’ cultural conceptualizations of mental illness, treatment providers may want to include members of the community who may be important to them, for example, clergy and other religious figures. It may be helpful to bring in respected members of the community such as religious clergy. Patients may benefit also from having a choice regarding contact with a religious provider and access to engaging in their specific religious practices, such as daily prayer and meditation. Friends Hospital offers pastoral care services in addition to formal mental-health and peer support. Patients may benefit from discussing their religious plan post discharge and other ways spiritual practices can be used to help further their recovery.

One way in which practitioners may be able to help ensure all services are recovery oriented in the inpatient psychiatric setting is through advocacy. Advocacy is a process that spans several domains related to the recovery model, such as inviting other mental-health professionals (including certified peer specialists) to be involved in implementing recovery-oriented services, providing trainings, and developing recovery-oriented committees that include former patients. Advocacy may help ensure that the “rubber hits the road” between implementing services and clients’ perceptions of them. In addition, mental-health professionals can advocate for more peer-supported trainings and services to help patients cross the barrier from consumers of services to providers. Also, advocacy can encompass requests for more research in order to identify how inpatient services could be more recovery oriented.

Limitations

This study had several limitations. The first limitation is that much data, such as group attendance, family contact, and peer support, were measured by reviewing charts after patients had discharged. Although most notes seemed to be present, some notes may not have been submitted to the chart. Also, in order to measure patient interaction with the peer support, the study relied on documented notes. Unfortunately, a review of the charts revealed that only 17 of 70 charts contained documentation, with approximately one note per chart documenting patient contact with the peer specialist. This data collection appears to be inconsistent with clients’ statements when they were asked to estimate the number of times they interacted with the peer specialists.

Also, patients were randomly selected for inclusion to the study based upon the researcher’s availability. Patients were interviewed between 7:30 to 8:30 a.m. in order to ensure no disruption in treatment. As a result of the limited time available to collect data throughout the

week, at least several patients who qualified as potential participants in the study were not interviewed.

Another limitation is that the study was carried out on two general adult inpatient units. Friends Hospital has five adult units overall. Therefore, an assumption that Friends Hospital overall is recovery oriented could be inaccurate. Further research may focus on collecting data from all eight including the geriatric, adolescent and high risk units to identify if Friends Hospital overall is offering recovery-oriented treatment.

Yet another potential limitation is that participants in the study were recruited toward the end of their hospital stay. Patients who are discharging may have biased their reporting toward a more positive evaluation given the anticipation of leaving the hospital. Therefore, the study does not measure patients' perceptions regarding their services throughout their treatment stay, even when the data collecting instrument directed patients to do so.

Cultural preferences of participants were not measured to determine if a recovery orientation is congruent with what a given person may have expected from his or her treatment providers. Some individuals might have been more comfortable with, for example, a psychiatrist telling them what medications work for a given condition or a therapist acting as an expert, similar to the role in more traditional medical models. Given that cultural preferences were not measured, data collection may not truly represent the level of recovery-oriented services offered.

Implications for Future Research

Future research should continue to investigate how to disseminate and implement recovery-oriented services in inpatient hospitals. Researchers should evaluate how to include patients in more of the decision-making when providing involuntary treatment services. Research could identify strategies and interventions that encourage patients admitted involuntarily to

engage in their treatment while recognizing they may be distressed as a result of temporarily losing their freedom. In addition to shared decision-making, researchers could also investigate how to engage families or other close support allies to participate in treatment in an inpatient environment. This research suggests that there could be an opportunity to develop brief family-oriented interventions that are specific to acute hospital admissions. Research needs to continue to examine positive outcomes that result from providing more recovery-oriented services. Studies need to examine if benefits occur in the realm of increased treatment engagement, increased satisfaction, increased carry-over of adherence to participation in community follow-up care, and reduced hospitalization. Lastly, more research should be completed on addressing and treating self-stigma. Researchers may also identify specific short-term interventions to identify and address patients who have internalized significant self-stigma.

The findings from the study suggest that patients who perceive services to be recovery oriented indicate higher rates of perceived shared decision-making with their treatment team and report lower self-stigma. This study suggests that patients perceive their services to be recovery oriented when their practitioners engage them in the decision-making process. Also, after receiving recovery-oriented treatment, patients will likely have a better understanding of the nature of mental illness and report reductions in self-stigma. Although the researcher did not find significant results with measuring peer contact and family engagement, the literature supports the inclusion of outside support in addition to treatment providers (Anthony, 1993). Including ancillary participants from the community is an important aspect of the recovery model. Although findings were statistically nonsignificant, one should note that patients did endorse these items on the RSA scale. Overall, the study supports the conclusion that practitioners who

want to provide a recovery-oriented environment will use interventions that include patients in decision-making and will address self-stigma.

References

- Adams, J. R., Drake, R. E., & Wolford, G. L. (2007). Shared decision-making preferences of people with severe mental illness. *Psychiatric Services, 58*(9), 1219-1221.
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation, 16*(4), 11-24.
- Anthony, W. A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychosocial Rehabilitation Journal, 24*(2), 159-167.
- Anthony, W. A., Rogers, S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal, 39*(2), 101-114.
- Bassman, R. (1997). The mental health system: Experiences from both sides of the locked doors. *Profession Psychology: Research and Practice, 28*(3), 238-242.
- Bathje, G. J., & Pryor, J. B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling, 33*(2), 161.
- Bellack, A. S. (2006). Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications. *Schizophrenia Bulletin, 32*(3), 432-442.
- Bellack, A.S., & Drapalskis, A. (2012). Issues and developments on the consumer recovery construct. *World Psychiatry, 11*(3), 156-160.
- Bieber, C., Müller, K. G., Blumenstiel, K., Schneider, A., Richter, A., Wilke, S & Eich, W. (2006). Long-term effects of a shared decision-making intervention on physician-patient interaction and outcome in fibromyalgia: A qualitative and quantitative 1 year follow-up of a randomized controlled trial. *Patient education and counseling, 63*(3), 357-366.
- Bradstreet, S. (2006). Harnessing the lived experience: Formalizing peer support approaches to promote recovery. *Mental Health Review Journal, 11*(2), 33 – 37.

- Brekke, J. S., & Mathisesn, S. G. (1995). Effects of parental involvement on the functioning of non-institutionalized adults with schizophrenia. *Psychiatric Services, 46*(11), 1149-1154.
- Campbell-Orde, T., Chamberlin, J. C., Carpenter, J., & Leff, H. S. (2005). Measuring the promise: A compendium of recovery measures, Volume II. Cambridge, MA: Evaluation Center@ Human Services Research Institute.
- Charles, C., Gafini, A., & Whelan, T. (1997). Shared decision-making in the medical encounter: What does it mean? (Or it takes at least two to tango). *Social Science and Medicine, 44*(5), 681-692.
- Chang, Y., Alley, S. H., Tamar, T., & Chen, M. D. (2013). Rasch Analysis of the Mental Health Recovery Measure. *American Journal of Occupational Therapy, 67*, 469-477.
- Ciompi, L. (1980). Catamnestic long-term study on the course of life and aging of schizophrenics. *Schizophrenia Bulletin, 6*(4), 606-618.
- Clark, R. E. (2001). Family support and substance use outcomes for persons with mental illness and substance use disorders. *Schizophrenia Bulletin, 27*(1), 93-101.
- Cleary, A., & Dowling, M. (2009). The road to recovery. *Mental Health Practice, 12*(5), 28-42.
- Copeland, M. E. (2001). Wellness Recovery Action Plan: A system for monitoring, reducing and eliminating uncomfortable or dangerous physical symptoms and emotional feelings. *Occupational Therapy in Mental Health, 77*, 127-150.
- Corrigan, P. (1998). The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice, 5*, 201-222.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614-625.

- Corrigan, P., Michaels, P. J., Vega, E., Gause, M., Watson, A. C., & Rusch, N. (1991). Self-Stigma of Mental Illness Scale-Short Form: Reliability and validity. *Psychiatry Research, 1*, 65-69.
- Corrigan, P. W., Slazer, M., Ralph, R., Sangster, T., & Keck, L. (2004). Examining the factor structure of the Recovery Assessment Scale. *Schizophrenia Bulletin, 30*(4), 1035-1041.
- Crane-Ross, D., Lutz, W. J., & Roth, D. (2006). Consumer and case manager perspectives of service empowerment: Relationship to mental health recovery. *The Journal of Behavioral Health Services & Research, 33*(2), 142-154.
- Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illness. *The British Journal of Psychiatry, 177*(1), 4-7.
- Cunningham, K., Wolbert, R., Graziano, A., & Slocum, J. (2005). Acceptance and change: The dialectic of recovery. *Psychiatric Rehabilitation Journal, 29*(2), 146-148.
- Daniles, A.S., Bergson, S., Fricks, L., Ashenden, P. & Powell, I. (2012) Pillars of peer support: Advancing the role of peer support specialists in promoting recovery. *The Journal of Mental Health Training, Education and Practice, 7*(2), 60-69.
- Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Profession Psychology: Research and Practice, 36*(5), 480-487.
- Deegan, P. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.
- Deegan, P. E., & Drake, R. F. (2006). Shared decision-making and medication management in the recovery process. *Psychiatric Services, 57*(11), 1636-1639.

- Deegan, P. E., Rapp, C., Holter, M., & Reifer, M. (2008). A program to support shared decision making in an outpatient psychiatric medication clinic. *Psychiatric Services*, 59(6), 603-605.
- Dickerson, F. B. (1998). Strategies that foster empowerment. *Cognitive and Behavioral Practice*, 5, 255-275.
- Drake, R. E., Deegan, P., & Rapp, C. (2010). The promise of shared decision-making in mental health. *Psychosocial Rehabilitation Journal*, 34(1), 7-13.
- Duncan, E., Best, C., & Hagen, S. (2010). Shared decision making interventions for people with mental health conditions. *Cochrane Database Syst Rev*, 1
- Eisen, S. V., Schultz, M. R., Mueller, L. N., Dengart, C., Clark, J., Resnick, S., Christian, C., Armstrong, M., Botanary, K., Rosenheck, R., & Sadow, D.: (2012). Outcome of a randomized study of a mental health peer education and support group in the VA. *Psychiatric Services*. 63,1243–1246.
- Eisen, S., Mueller, L., Chang, B. H., Resnick, S., Schilts, M., & Clark, J. (2015). Mental health and quality of life among veterans employed as peer and vocational rehabilitation specialists. *Psychiatric Services*. 66(4), 381-388.
- Evert, H., Harvey, C., Trauer, T., & Herrman, H. (2003). The relationship between social networks and occupational and self-care functioning in people with psychosis. *Social Psychiatry Epidemiology*, 38, 180-188.
- Federici, M. R. (2013). The importance of fidelity in peer-based programs: The case of the Wellness Recovery Action Plan. *Psychiatric Rehabilitation Journal*, 36(4), 314.
- Field, A. (2013). *Discovering statistics using IBM SPSS statistics*. Thousand Oaks C.A.Sage.

- Frese, F. J., & Davis, W. W. (1997). The consumer-survivor movement, recovery, and consumer professionals. *Professional Psychology: Research and Practice*, 28(3), 243-245.
- Frese, F. J., Stanley, J., & Kress, K., Voegel-Scibilla, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric Services*, 52(11), 1462-1468.
- Frosch, D. L., & Kaplan, R. M. (1999). Shared decision-making in clinical medicine: Past research and future directions. *American Journal of Preventative Medicine*, 17(4), 285-294.
- Gagne, C., White, W., & Anthony, W. (2007). Recovery: A common vision for the fields of mental health and addiction. *Psychiatric Rehabilitation*, 31(1), 32-37.
- Glynn, S. M., Cohen, A. N., Dixon, L. B., & Niv, N. (2006). The potential impact of the recovery movement on family interventions for schizophrenia: Opportunities and obstacles. *Schizophrenia Bulletin*, 32(3), 451-463.
- Grenden, J. F., Valenstien, M., Spinner, J., Blow, A., Gorman, L. A., Dalack, G. W., . . . Kees, M. (2010). Buddy to Buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression and suicide. *Annual New York Academy of Science*. 1206, 90-97.
- Harrison, G., Hopper, K., Laska, E., Siegel, C., Wanderling, J., Dube, K. C., Genev, K., Giel, R., Der Heiden, W., Homberg, S., Janeka, A., Lee, P., Leon, C., Malhorthra S., Marsela, A., Nakane, Y., Sartiouros, N. Shen, Y., Skoda, C., Tsirgen S., Varma, V., Walsh, D., & Wiersma, D.. (2001). Recovery from psychotic illness: A 15 and 25 year international follow up study. *The British Journal of Psychiatry*, 178, 506-514.
- Hayward, P., & Bright, J. A. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health* 6(4), 345-354.

- Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies from the states. *Psychiatric Rehabilitation Journal*, 23(4), 333-341.
- Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4), 482-485.
- Jerrell, J. M., Cousins, V. C., & Roberts, K. M. (2006). Psychometrics of the Recovery Process Inventory. *The Journal of Behavioral Health Services & Research*, 33(4), 464-473.
- Joosten, E., Defuentes-Merillas, L., Weert, G. H., Sensky, T., van der Staak, C. P. F., & Jong, C. A. J. (2008). Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence, and health status. *Psychotherapy and Psychosomatics*, 77, 219-226.
- Kelly, M., & Gamble, C. (2005). Exploring the concept of recovery in schizophrenia. *Journal of Psychiatric and Mental Health Nursing*, 12, 245-251.
- Kihlstrom, J. F. (2002). To honor Kraepelin...: From symptoms to pathology in the diagnosis of mental illness. Beutler, L (Ed): Malik, M (Ed) (2002) Rethinking the DSM: a psychological perspective. Decade of Behavior (pp. 279-303) Washington, DC, US: American Psychological Association, xiii, 331pp
- Link, B. G., Stuenkel, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). The consequences of stigma for the self-esteem of people with mental illness. *Psychiatric Services*, 52(12), 1621-1626.
- Lloyd, C., Waghorn, G., & Williams, P. L. (2008). Conceptualizing recovery in mental health rehabilitation. *British Journal of Occupational Therapy*, 71(8), 321-328.

- Malinovsky, I., Leher, P., Silverstein, S. M., Shankman, S., O'Brien, W., Samuelson, T., et al. (2013). An empirical evaluation of recovery transformation at a large community psychiatric rehabilitation organization. *Psychiatric Services, 10*(4), 428-441.
- Mandelblatt, J., Kreling, B., Fugeuriedo, M., & Feng, S. (2006). What is the impact of shared decision-making on treatment and outcomes for older women with breast cancer? *Journal of Clinical Oncology, 24*(30), 4908-4913.
- Matthias, M. S., Salyers, M. P., Rollins, A. L., & Frankel, R.. (2012). Decision-making in recovery-oriented mental health care. *Psychosocial Rehabilitation, 35*(4), 305-314.
- McCraine, A. (2011). Recovery in mental illness: The roots, meanings, and implementations of a "new" services movement. In D. Pilgram, A. Rogers & B. Pescosolido (Eds.), *The SAGE handbook of mental health and illness* (pp. 471-488). Thousand Oaks, CA: Sage.
- McFarlane, W. R., Dixon, L., & Lucksted, A. (2003). Family psycho-education and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy, 29*(2), 223-245.
- Moran, G. S., Russinova, Z., & Stepas, K. (2012). Toward understanding the impact of occupational characteristics on the recovery and growth processes of peer providers. *Psychiatric Rehabilitation Journal, 35*(5), 376-380.
- Mueser, K. T., Sengupta, A., Schooler, N. R., Bellack, A. S., Xie, H., Glick, I. D., & Keith, S. J. (2001). Family treatment and medication dosage reduction in schizophrenia: Effects on patient social functioning, family attitudes, and burden. *Journal of Consulting and Clinical Psychology, 69*(1), 3.
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report* (DHHS Pub. No. SMA-03-3831). Rockville,

- MD: Substance Abuse and Mental Health Services Administration. Retrieved from <http://store.samhsa.gov/product/SMA03-3831>
- O'Connell, M. J., Tondora, J., Croog, G., Evans, A. C., & Davidson, L. (2005). From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychosocial Rehabilitation Journal*, 28(4), 378-386.
- Patel, S. R., Bakken, S., & Ruland, C. (2008). Recent advances in shared decision-making for mental health. *Current Opinion in Psychiatry*, 21(6), 606-612.
- Puschner, B., Neumann, P., Jordan, H., Fiorillo, A., Giacco, D., Egerhazi, A., et al. (2013). Development and psychometric properties of a five-language multi-perspective instrument to assess clinical decision-making style in the treatment of people with severe mental illness (CDMS). *Biomedical Central Psychiatry*, 13(48)1.
- Reisner, A. D. (2005). The common factors, empirically validated treatments, and recovery models of therapeutic change. *The Psychological Record*, 55, 377-399.
- Resnick, S. G., & Rosenheck, R. A. (2008). Integrating peer-provided services: A quasi-experimental study of recovery orientation, confidence and empowerment. *Psychiatric Services*, 59, 1307-1314. doi:10.1176/appi.ps.59.11.1307
- Rissmiller, D. J., & Rissmiller, J. H. (2006). Evolution of the antipsychiatry movement in mental health consumerism. *Psychiatric Services*, 57(6), 863-866.
- Russinova, Z., Rogers, S., Ellison, M. L., & Lyass, A. (2011). Recovery-promoting professional competencies: Perspectives of mental health consumers, consumer-providers, and providers. *Psychiatric Rehabilitation Journal*, 34(3), 177-185.
- Salyerm, M. P., Jack, T., & Stultz, T. (2007). Measuring recovery orientation in a hospital setting. *Psychiatric Rehabilitation Journal*, 31(2), 131-137.

- Salzer, M., Schwenk, E., & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: Results from a national survey. *Psychiatric Services, 61*(5), 520-523.
- Solomon, P. (2004). Peer support/peer provided services: Underlying process, benefits, and critical ingredients. *Psychosocial Rehabilitation Journal, 27*(4), 392-401.
- Solomon, P., Draine, J., Mannion, E., & Meisel, M. (1996). Impact of brief family psychoeducation on self-efficacy. *Schizophrenia Bulletin, 22*(1), 41.
- Solomon, P., & Stanhope, V. (2004). Recovery: Expanding the vision of evidence-based practice. *Brief Treatment and Crisis Intervention, 4*(4), 311-321.
- Sowers, W. (2005). Transforming systems of care: The American Association of Community Psychiatrists guidelines for recovery-oriented services. *Community Mental Health Journal, 41*(6), 757-774.
- Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. (2005). *National Summit on Recovery*, September 28-29, 2005, Washington, D.C.
- Tomes, N. (2006). The patient as a policy factor: A historical case study of the consumer/survivor movement in mental health. *Health Affairs, 25*(3), 720-729.
- Williams, R., Bambara, J. & Turner, A.(2012). A scoping study of one to one peer mentorship interventions and recommendations for the application with veterans with post deployment syndrome. *Journal of Head Trauma Rehabilitation, 27*(4), 261-273.

Appendix A

Client Demographic Sheet

1. Philadelphia resident? Yes or No
2. Are you currently employed? Yes or No
 - a. If yes Part time or Full time
3. Were you in an inpatient hospital before? Yes or No
4. If so, how many previous admissions? _____
5. What was your admission status? Voluntary or Involuntary
6. Whose idea was it for you to go to the hospital? _____
7. Do you currently seek outpatient treatment? Yes or No
8. Do you currently take any medication to address psychiatric symptoms? Yes or No
9. Current diagnosis _____
10. Do you have a history of substance abuse? Yes or No
11. If so do you attend outside meetings such as 12 step support groups? Yes or No
12. Do you engage with any peer supports while you were at Friends? Yes or No
 - If yes was it helpful or not ? _____
 - Approximately how many times did you see the peer support specialist? _____
 - If no any reason why not ? _____
13. Do you engage with any peer supports in the community? Yes or No
14. If so do you find them helpful? _____
15. Do you have any significant medical issues?
16. Medical conditions _____
17. Do you have recent contact with family members? Yes or No

18. Do you feel your aftercare services will meet all of your needs when you discharge? Yes or

No

19. Were efforts made to contact your family/outside support and bring them in for family

therapy? Yes or No

a. If yes Did they come ? _____

i. Approximately how many times did you have contact with your family?

_____ In person _____ On the phone _____

b. If no Why not? _____

Appendix B**Chart Demographic Sheet**

1. Race: _____
2. Age _____
3. Gender _____
4. Relationship Status _____
5. Education Level: _____
6. Length of stay: _____
7. Admission Status 302 201
8. Gaf Intake : _____
9. Gaf Discharge: _____
10. Number of attended groups full: _____
11. Number of attended groups partial: _____
12. Number of notes regarding family contact: _____
13. Number of PRN's administered: _____
14. Number of notes regarding peer support group _____

*Appendix C

O'Connell, Tondora, Kidd, Stayner, Hawkins, and Davidson (2007)

RSA-R**Person in Recovery Version**

Please circle the number below which reflects how accurately the following statements describe the activities, values, policies, and practices of this program.

1	2	3	4	5
Strongly Disagree	Disagree		Agree	Strongly Agree

N/A= Not Applicable
D/K= Don't Know

1. Staff welcome me and help me feel comfortable in this program. 1 2 3 4 5 N/A D/K
2. The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified. 1 2 3 4 5 N/A D/K
3. Staff encourage me to have hope and high expectations for myself and my recovery. 1 2 3 4 5 N/A D/K
4. I can change my clinician or case manager if I want to. 1 2 3 4 5 N/A D/K
5. I can easily access my treatment records if I want to. 1 2 3 4 5 N/A D/K
6. Staff do not use threats, bribes, or other forms of pressure to get me to do what they want. 1 2 3 4 5 N/A D/K
7. Staff believe that I can recover. 1 2 3 4 5 N/A D/K
8. Staff believe that I have the ability to manage my own symptoms. 1 2 3 4 5 N/A D/K
9. Staff believe that I can make my own life choices regarding things such as where to live, when to work, whom to be friends with, etc. 1 2 3 4 5 N/A D/K
10. Staff listen to me and respect my decisions about my treatment and care. 1 2 3 4 5 N/A D/K
11. Staff regularly ask me about my interests and the things I would like to do in the community. 1 2 3 4 5 N/A D/K
12. Staff encourage me to take risks and try new things. 1 2 3 4 5 N/A D/K
13. This program offers specific services that fit my unique culture and life experiences. 1 2 3 4 5 N/A D/K
14. I am given opportunities to discuss my spiritual needs and interests when I

wish. 1 2 3 4 5 N/A D/K

15. I am given opportunities to discuss my sexual needs and interests when I wish. 1 2 3 4 5 N/A D/K

16. Staff help me to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies). 1 2 3 4 5 N/A D/K

17. Staff help me to find jobs. 1 2 3 4 5 N/A D/K

18. Staff help me to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies. 1 2 3 4 5 N/A D/K

19. Staff help me to include people who are important to me in my recovery/treatment planning (such as family, friends, clergy, or an employer). 1 2 3 4 5 N/A D/K

20. Staff introduce me to people in recovery who can serve as role models or mentors. 1 2 3 4 5 N/A D/K

Code: _____

Appendix D

SSMIS-SF

Name or ID Number _____ Date _____

The public has believed many different things about persons with serious mental illnesses over the years, including some things that could be considered offensive. We would like to know what you think most of the public as a whole, or most people in general, believe about persons with serious mental illnesses at the present time. Please answer the following items using the 9-point scale below.

I strongly disagree I strongly agree

Disagree nor disagree agree

 1 2 3 4 5 6 7 8 9

Section 1:

I think the public believes...

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

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Section 2:

Now answer the next 5 items using the agreement scale.

I strongly disagree I strongly agree

Disagree nor disagree agree

1 2 3 4 5 6 7 8 9

I think...

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

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Section 3

Now answer the next 5 items using the agreement scale.

I strongly neither agree I strongly

Disagree nor disagree agree

1 2 3 4 5 6 7 8 9

Because I have a mental illness...

1. _____ I am unable to take care of myself.
2. _____ I will not recover or get better.
3. _____ I am to blame for my problems.
4. _____ I am unpredictable.
5. _____ I am dangerous.

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Section 4

Finally, answer the next 5 items using the agreement scale.

I strongly neither agree I strongly

Disagree nor disagree agree

1 2 3 4 5 6 7 8 9

I currently respect myself less...

1. _____ because I am unable to take care of myself.
2. _____ because I am dangerous.
3. _____ because I am to blame for my problems.
4. _____ because I will not recover or get better.
5. _____ because I am unpredictable.

Clinical Decision Making Style – Service User (CDMS-P)

A. These questions are about your attitudes towards decision-making in mental health-care. Please tick to what extent you agree with the following statements (from “strongly disagree” to “strongly agree”).

	<i>Strongly disagree</i>	<i>Slightly disagree</i>	<i>Neither disagree or agree</i>	<i>Slightly agree</i>	<i>Strongly agree</i>	
1. Important decisions should be made by the clinician in charge and not by me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP01]
2. Even if I have a different opinion than my clinician, I should still follow his/her advice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP02]
3. If I have to be treated in hospital, I shouldn't make my own decisions concerning my treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP03]
4. I should make my own decisions concerning everyday problems connected to my illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP04]
5. If my illness gets worse, I want my clinician to take more control of my treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP05]
6. I should decide for myself how often I want to see my clinician.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP06]

B. Here are some case examples. Please read them thoroughly and answer the questions relating to them by ticking the items that best apply to you.

Case example 1: Imagine you are on the road to recovery after a critical stage of your illness and now you would like to return to your place of work/occupation.

Who should make the following decisions?

	<i>Me</i>	<i>Mainly me</i>	<i>Jointly with clinician</i>	<i>Mainly clinician</i>	<i>Clinician</i>	
7. If I can return to work at all.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP07]
8. What type of occupation would be suitable (e.g. less demanding or the same as before)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP08]
9. How much I should work (part-time or full-time)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP09]

Case example 2: Imagine that you experience unusually severe side effects due to your medication.

Who should make the following decisions?

	<i>Me</i>	<i>Mainly me</i>	<i>Jointly with clinician</i>	<i>Mainly clinician</i>	<i>Clinician</i>	
10. If I should see a doctor because of this.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP10]
11. If the present medication dosage should be changed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP11]
12. If I should take another medication.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP12]

Case example 3: Your clinician suggests you take medication for your mental health problems.

Who should make the following decisions?

	<i>Me</i>	<i>Mainly me</i>	<i>Jointly with clinician</i>	<i>Mainly clinician</i>	<i>Clinician</i>	
13. If I take this medication at all.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP13]
14. In what form I take it (e.g. depot, tablets)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP14]
15. How long I take the drugs for?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP15]

C. The following questions refer to your need for information as a service user. Please indicate how much you agree with each statement.

	<i>Strongly disagree</i>	<i>Slightly disagree</i>	<i>Neither disagree or agree</i>	<i>Slightly agree</i>	<i>Strongly agree</i>	
16. The more my illness worsens, the more I should be informed about the facts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP16]
17. I should know exactly what is going to happen to me regarding my illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP17]
18. The clinician should explain to me the purpose of examinations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP18]
19. I should only receive information when I ask for it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP19]
20. It's important for me to know all the side-effects of my treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP20]
21. If various treatment methods are possible then I should be informed about them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	[CDMSP21]