Evaluation of Recovery-oriented Acute INpatient Mental Healthcare

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Polling Questions

Rationale

- There have been numerous efforts to define, measure, and support the implementation of recovery-oriented care in outpatient settings.
  - Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial rehabilitation journal, 16(4), 11.
  - Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial rehabilitation journal, 11*(4), 11.
- However, recovery-oriented *inpatient* care has received relatively less attention.
- Nonetheless, inpatient care is an important part of the recovery journey for many persons with mental illness.

Background

- 9/18/2013- VHA-wide distribution of the new Inpatient Mental Health Services Handbook (VHA Handbook 1160.06)
  - **Recovery Services Toolkit:** "a Toolkit and related guidance for use of the Toolkit for the implementation of recovery principles and practices for VHA inpatient units"
  - As part of the Toolkit, the **Inpatient Recovery Checklist** was developed as a guide for "systematic implementation of recovery-based services".

- Despite these great efforts, there had not been any *systematic assessment* of recovery-oriented inpatient care w/in VA

Study Aims

- Aim 1: Assess the penetration of recovery-oriented inpatient care across the VHA.
- Aim 2: Describe the implementation process, including challenges and strategies to overcome them, used by sites to implement elements of recovery-oriented care.
- Aim 3: Examine the relationship between recovery-oriented inpatient care and Veteran outcomes.

Overview: Mixed Qual/Quant

- Define Recovery-Oriented Inpatient Care
- Measure ROC at Sites
- Understand Implementation
- Test Association: ROC & Outcomes

Operationalizing Recovery-Oriented Inpatient Care

THE RAIN SCALE

Where to start?

- Numerous definitions exist
  - Often general or abstract- not operationalized
  - How do you choose the best?
- VA Checklist
  - Meant for VA
  - Tied to policy
  - However, Checklist intended for self-assessment & QA

Checklist Modification

- Wording sometimes not clear to research team
  - E.g., periodic "reality check"
- Multiple aspects of care rated in an item
  - I.e., "double-barreled"
- Anchors not precise enough
  - 3-pt. scale
- Needed more objective criteria

Continuous Development

- Initial Scale
- Site scoring meetings after each visit
- Notes from meetings collated and reviewed by the full team
- Periodic reviews of the literature
- Review by partners at the VA Office of Mental Health and Suicide Prevention and inpatient program coordinator

RAIN Scale

- 23 items
- 5-Point Rating Scale
  - 2.0 Excellent quality and consistency (deviations or deficits rare)
  - 1.5 Good quality and consistency (some deviations or minor deficits)
  - 1.0 Regular deficits in consistency *OR* quality
  - 0.5 Regular deficits in consistency *AND* quality
  - 0.0 Little or no goal setting

- Scoring Criteria

Scale Organization

4 subscales based on CFA (still ongoing)

- Inpatient Treatment Planning
- Outpatient Treatment Planning
- Group Programming
- Milieu

Inpatient Treatment Planning

- Recovery-oriented Goal Setting
- Written Treatment Plan
- SDM for Medication Management
- SDM for Inpatient Treatment
- Interdisciplinary Treatment Team
- Family/Significant Other Involvement

Outpatient Treatment Planning

- SDM for Outpatient Treatment
- Outpatient Care Coordination
- Least Restrictive Discharge
- In-Reach

Group Programming

- Sufficient Volume of Group Programming
- Sufficient Group Variety
- Support for Programming
- High Quality Programming

Milieu

- Warm & Inviting Unit
- Autonomy Promoting Environment
- Respectful Therapeutic Interactions
- Behavior Managed Through Least Restrictive Means

Other (Non-factor Items)

- Integrated Care for Comorbid Physical Health
- Individual Evidence-Based Psychotherapy
- Suicide Prevention
- Multiple Disciplines Represented
- Peer Support

Assessing ROC Within VA

Sample Sites

- **Acute inpatient mental health units at 34 VAMCs:**
  - Representing every major region of the country
  - 16 different VISNs
  - Rural (n=3, 9%) and urban (n=31; 91%) setting

Data Sources

- Data collection included several sources:
  - Observations from 2-day site visits
  - Key informant (staff) interviews
  - Veteran interviews
  - Administrative data
  - Chart reviews

Staff Key Informants

- Average of 4.4 key informant interviews were conducted for each site (range 3 to 7)
- Targeted:
  - Unit Nurse Manager
  - Medical Director/Lead Psychiatrist
  - Program Coordinator
  - Social Worker
  - Local Recovery Coordinator
- 1 hour
- Semi-structured (phone)
- Implementation of elements
- Implementation process

Sample

- **Veteran interviews**
  - Average of 5.7 veteran interviews were conducted for each site (range 4 to 9)
  - Over half of Veterans interviewed were White (56%)
  - One-third were Black or African American (33%)
  - Small number were Hispanic or Latino (9%)
  - Majority of participating Veterans were male (79%)

Scoring

- Raters
  - Members of Study Team
  - Decades experience as providers, consultants, researchers, and family members
- Primary rater (secondary and tertiary raters when necessary).
  - Coordinated data collection
  - Led site visit
  - Drafted a preliminary site summary
- A site scoring meeting
  - ≥4 raters
  - consensus.

Results

Levels of Implementation

Common

- Sufficient Volume of Group Programming
- Respectful Therapeutic Interactions
- Autonomy Promoting Environment
- Outpatient Care Coordination

Very Common

- Integrated Care for Comorbid Physical Health
- Suicide Prevention
- High Quality Programming
- Behavior Managed Through Least Restrictive Means

Uncommon

- SDM for Outpatient Treatment
- Least Restrictive Discharge
- In-Reach
- Support for Programming
- Warm & Inviting Unit
- Peer Support
- Interdisciplinary Treatment Team
- Family/Significant Other Involvement

Very Uncommon

- Written Treatment Plan
- Recovery-Oriented Goal Setting
- SDM for Medication Management
- SDM for Inpatient Treatment
- Individual Evidence-Based Psychotherapy

Inpatient Treatment Planning

	0	.5	1.0	1.5	2.0	Mean	S.D.
RAIN Mean Revised	-	-	-	-	-	1.21	.22
Inpatient Treatment Planning	-	-	-	-	-	.87	.35
1. Recovery-oriented goal setting	5 (14.7%)	13 (38.2%)	10 (29.4%)	5 (14.7%)	1 (2.9%)	.77	.51
2. Written Treatment Plan	2 (5.9%)	6 (17.6%)	20 (58.8%)	6 (17.6%)	0 (0%)	.94	.38
3. SDM for Medication Management	8 (23.5%)	10 (29.4%)	9 (26.5%)	6 (17.6%)	1 (2.9%)	.74	.57
4. SDM for Inpatient Treatment	10 (29.4%)	16 (47.1%)	6 (17.6%)	2 (5.9%)	0 (0%)	.50	.43
22. Interdisciplinary Treatment Team	3 (8.8%)	8 (23.5%)	8 (23.5%)	10 (29.4%)	5 (14.7%)	1.09	.61
23. Family/Significant Other Involvement	0 (0%)	6 (17.6%)	16 (47.1%)	4 (11.8%)	8 (23.5%)	1.21	.52

Outpatient Treatment Planning

	0	.5	1.0	1.5	2.0	Mean	S.D.
Outpatient Treatment Planning	-	-	-	-	-	1.20	.35
5. SDM for Outpatient Treatment	0 (0%)	10 (31.3%)	12 (37.5%)	7 (21.9%)	3 (9.4%)	1.05	.48
6. Outpatient Care Coordination	0 (0%)	6 (17.6%)	6 (17.6%)	13 (38.2%)	9 (26.5%)	1.37	.53
7. Least Restrictive Discharge	0 (0%)	10 (29.4%)	10 (29.4%)	10 (29.4%)	4 (11.8%)	1.12	.51
8. In-Reach	0 (0%)	4 (11.8%)	15 (44.1%)	9 (26.5%)	6 (17.6%)	1.25	.46

Group Programming

	0	.5	1.0	1.5	2.0	Mean	S.D.
Group Programming	-	-	-	-	-	1.38	.34
12. Sufficient Volume of Group Programming	0 (0%)	3 (8.8%)	10 (29.4%)	10 (29.4%)	11 (32.4%)	1.43	.49
13.1 Revised Group Dimensions	-	-	-	-	-	1.61	.41
13. Sufficient Group Variety	1 (2.9%)	17 (50%)	0 (0%)	2 (5.9%)	14 (41.2%)	1.16	.76
14. Support for Programming	4 (11.8%)	6 (17.6%)	14 (41.2%)	6 (17.6%)	4 (11.8%)	1.00	.58
15. High Quality Programming	0 (0%)	2 (5.9%)	6 (17.6%)	17 (50%)	9 (26.5%)	1.49	.42

Milieu

	0	.5	1.0	1.5	2.0	Mean	S.D.
Milieu	-	-	-	-	-	1.36	.36
16. Warm & Inviting Unit	1 (2.9%)	8 (23.5%)	9 (26.5%)	12 (35.3%)	4 (11.8%)	1.15	.53
17. Autonomy Promoting Environment	1 (2.9%)	3 (8.8%)	12 (35.3%)	11 (32.4%)	7 (20.6%)	1.29	.51
18. Respectful Therapeutic Interactions	1 (2.9%)	5 (14.7%)	8 (23.5%)	10 (29.4%)	10 (29.4%)	1.34	.57
19. Behavior Managed Through Least Restrictive Means	0 (0%)	2 (6.1%)	2 (6.1%)	11 (33.3%)	18 (54.5%)	1.68	.43

Non-factor Items

	0	.5	1.0	1.5	2.0	Mean	S.D.
Non-Factor Items	-	-	-	-	-		
9. Integrated Care for Comorbid Physical Health	0 (0%)	0 (0%)	2 (5.9%)	7 (20.6%)	25 (73.5%)	1.84	.29
10. Individual Evidence-Based Psychotherapy	17 (50%)	3 (8.8%)	11 (32.4%)	3 (8.8%)	0 (0%)	0.50	.55
11. Suicide Prevention	0 (0%)	0 (0%)	2 (5.9%)	8 (23.5%)	24 (70.6%)	1.82	.30
20. Multiple Disciplines Represented	0 (0%)	10 (29.4%)	9 (26.5%)	10 (29.4%)	5 (14.7%)	1.15	.53
20.1 Revised Disciplines' Subjective Adequacy	-	-	-	-	-	1.66	.24
21. Peer Support	5 (14.7%)	8 (23.5%)	8 (23.5%)	3 (8.8%)	10 (29.4%)	1.07	.73

Discussion

- Development of this scale is a big gain toward conceptualizing and operationalizing recovery-oriented care in the context of acute inpatient mental health care

- Content validity is strong
  - Consistent with extant literature
    - Patient perspectives
    - Staff/provider perspectives
    - Other implementation efforts

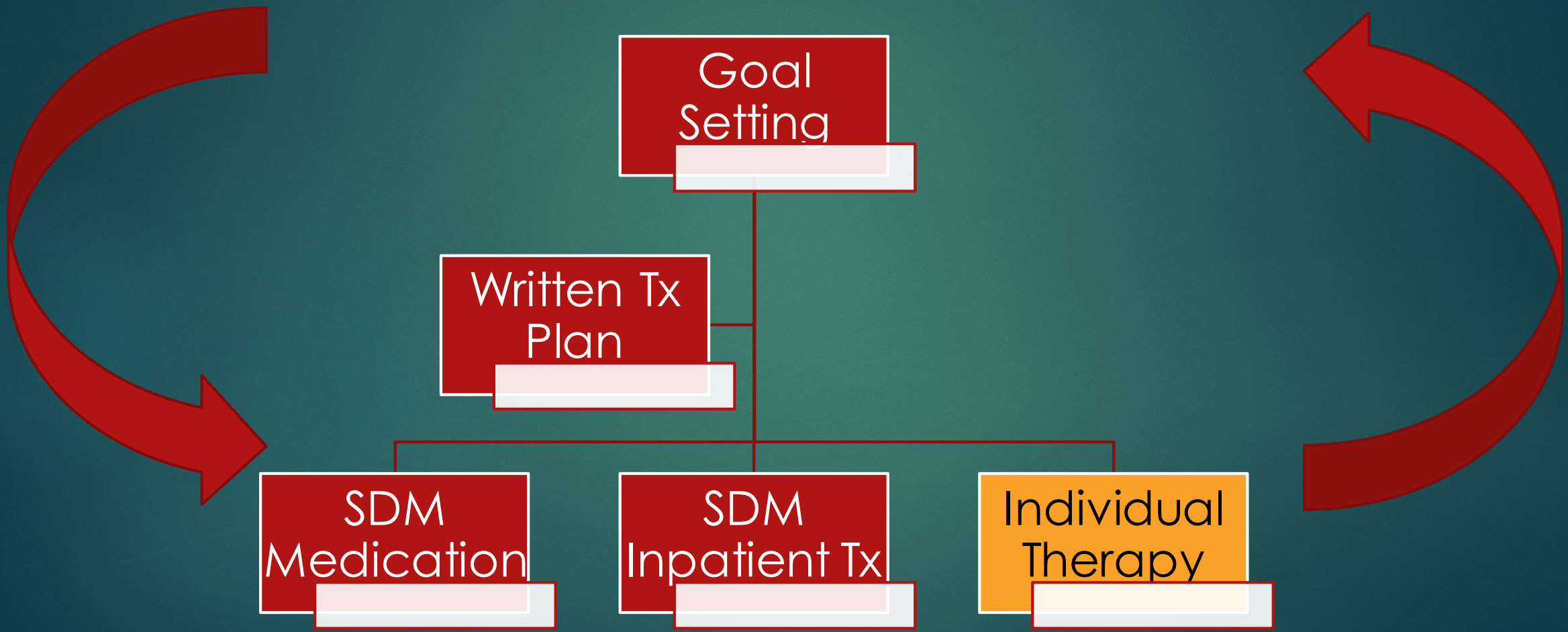
Not done yet

- Psychometrics
  - Item level issues
  - Factor analysis not strong fit
- Feedback
  - Field
  - Peer review
- Outcomes

VA Successes

- Suicide Prevention
- Behavior Management
- Integration of Physical Health
- Quality Programming

Urgent Attention Needed



Implementation Data (Preliminary Thoughts)

- Data analysis on-going
- Data is sparse- Why?
  - Common understanding of concepts took a long time
  - Institutional amnesia
  - No singular "launch" at sites
- Model specificity a barrier or facilitator, depending on the item
  - 40 HOURS OF PROGRAMMING!!!!
  - VS. SDM or Goal-setting

Other Barriers

- Focus on Safety and Acute Stabilization
- Medical Model Focused Prescribers

- "Yes. It's basically I find that the treatment team meetings are I guess like **90% about discussions about medications** and there is very little room for psychosocial type issues. I believe that our psychiatrist is totally grounded in biological processes and totally believes in those and therefore there's- psychosocial issues are either discounted or they're farmed out to the social workers." – Psychologist/Treatment Coordinator

Facilitators

- Not necessarily sufficient (or necessary)
- Staffing
  - E.g., No psychologist = no therapy
- Champion
  - Helpful (but can be trumped)

Future Directions

- For out team
  - Assess relationship with Veteran outcomes
  - Analyze implementation data

- Need evidence-base for
  - Inpatient programming (individual & group)
  - Specific models of goal-setting
  - Specific models of shared decision-making

Thank you!

QUESTIONS & DISCUSSION