Estimation of personal recovery from mental illness using Mini-Service user Recovery Evaluation scale, (Mini-SeRvE)

Background:

Concept of personal recovery

Mental health service users and the clinicians caring for them may rate their recovery differently, (Bonney & Stickley 2008, Perkins, 2001, Stotland et al 2008). Clinicians tend to assess remission of clinical symptoms, (Fawcett, 2007), whereas service users often prioritise having a satisfying and meaningful life, (Corrigan et al. 1999, Fawcett, 2007, Slade et al. 2008). We will call the service user experience of recovery: "personal recovery". We hypothesise that a significant minority of service users have needs compromising their personal recovery, which are not being identified by clinicians or met by standard clinical interventions. The eventual goal of this project is to develop and evaluate appropriate interventions for helping these people.

Importance of measuring personal recovery

In order to study how far personal recovery is independent of the clinical assessment of recovery in service users, it is necessary to compare changes in both over a period of time. For this, a suitable measure of personal recovery is required. In addition, if new interventions are introduced to facilitate personal recovery, these will need to be evaluated for their effectiveness using quantitative studies. Again, it is crucial that an appropriate outcome measure is identified. Such a measure needs to include issues commonly considered of prime importance by service users for their personal recovery.

Need for a new self-report recovery scale

There are already many self-report recovery scales designed with the aim of capturing personal recovery: for reviews see Law & Morrison, (2012), Shanks et el, (2013), Sklar et al., (2013). Qualitative studies have identified themes important to service users, (Leamy et al., 2011; McCabe et al., 2007), including meaning, hope, and empowerment, and some tools have been developed based upon these issues, eg. (The Questionnaire about the Process of Recovery, (Neil et al., 2009)). However, given the accepted importance of spirituality to mental health service users, (Borras et al., 2007, Fallot, 2007), and the fact that many service users need help with spiritual/religious issues, (Galanter, 2011, Barber & Wilson, 2014), we were concerned that these issues have not been sufficiently represented in existing measures. By "spirituality" we mean that which gives meaning and purpose to life. It usually concerns the transcendent and often, but not always, a particular religious faith, (Barber & Wilson, 2014; Cook, 2004). For some people, the problems they have with personal recovery may be spiritual in origin. Many value spiritual care, (Recker & Menke, 2013). It was therefore decided to design a new tool, in the hope of identifying, monitoring and helping these people more effectively. This tool, the Service user Recovery Evaluation scale, (SeRvE) has now been developed and validated, (Barber et al., 2012).

The Service user Recovery Evaluation scale, (SeRvE).

This tool was completely user-designed to focus on issues service users themselves find important for their personal recovery. The principal investigator was a service user, working with extensive input from a research forum of service users, (Suresearch), and a service user steering group meeting monthly. A scoping day was held with 30 service users to identify all issues they considered relevant, including the spiritual and religious. A total of 67 questions were drawn up as a result, forming the provisional SeRvE, which was then completed by 100 service users in secondary mental health care. After analysis of the results, 40 questions remained. The religious section is marked optional and is designed to be relevant to people of many different faiths and creeds. Factor analysis confirmed the importance of spiritual and religious issues for many service users. Results found SeRvE to be a reliable and valid measure of recovery in this client group.

The Mini-SeRvE scale.

At 40 questions, SeRvE is too long for routine use, or even for research purposes when participants have severe mental illness, (Moeser et al., 2006; Boyer et al., 2010). It was therefore decided to create Mini-SeRvE, a shortened version of SeRvE, (Barber et al., 2017). This was done using statistical methods from the factor analysis of SeRvE, ,(a method employed by Wardenaar et al., 2010 and Pargament et al., 2011), coupled with much qualitative feedback from our service user groups. The finalised Mini-SeRvE was completed by 100 users, and factor analysis again confirmed the importance of spiritual and religious issues. Results showed 3 clearly definable subscales:

1. Existential well-being, (EWB) eg. concerning a sense of meaning and purpose for life in general;
2. Mental ill-being, (MIB), eg. concerning common problems with mental well-being like agitation, isolation or lack of motivation;
3. Religious well-being, (RWB), eg. concerning how far religion is helpful to you in life.

Like SeRvE, Mini-SeRvE was found to be a reliable and valid measure of recovery in this client group.

The current study

As yet, we have not tested our new tools for sensitivity to change or test-retest reliability. This needs to be done to complete validation of SeRvE and Mini-SeRvE so they can be used to monitor personal recovery. In this current study, our primary aim is to do this for Mini-SeRvE, as it is the more practical for widespread use. Our secondary aim is to investigate the changes of scores on the Mini-SeRvE subscales over time with respect to each other. The population that has been chosen for the study is a sample of people with mental health problems attending mental health counseling over a period of 10 weeks, during which positive holistic mental health is the primary focus. It would be expected that this sample of people would score an improvement on Mini-SeRvE over time, allowing the calculation of sensitivity to change and test-retest reliability, and comparison of the changes in the different Mini-SeRvE subscales over time. A third aim is to explore the experience that the counselors have of using Mini-SeRvE in a clinical setting. For this, a focus group of counselors will be convened.

Aims:

To test Mini-SeRvE for sensitivity to change and test-retest reliability.
To study the longtitudinal relationship between the 3 concepts identified during the development of Mini-SeRvE, (EWB, MIB, RWB).
To study the counselors' views of the usefulness of Mini-SeRvE in practice.

Objectives:

To monitor personal recovery over time using Mini-SeRvE in a group of clients with mental health problems.
To compare these results with a global self-rating of recovery completed at the end of the counseling.
To compare changes in each of the 3 subscales of Mini-SeRvE as they occur over time
To qualitatively explore the experience of counselors using Mini-SeRvE.

Quantitative phase

Methodology:.

Sample:

This would be a sample of 100 people just enrolled with a mental health counseling service. Exclusion criteria would be under 18, cognitive dysfunction or learning disability, inability to speak and/or understand English.

Study design:

Potential participants will be identified when arriving for their first session of counseling and asked by the counselor whether or not they would be prepared to participate in the study. Clients who are agreeable will then be approached by one of the research team who will explain what it would mean for them to participate. They will then be given the opportunity to ask questions, and those who are agreeable will sign a consent form. For those who have given consent, demographic details will be collected, including age group, gender, ethnicity and religion if any. They would be asked to say whether they are in primary or secondary NHS mental health care, or if they are not under NHS care for their mental health.

Clients at this counselling service routinely complete GAD and PSQ9 weekly before their counselling session. Those who agree to participate will also complete the Mini-SeRvE scale each week. At their first session they will also give a self-rating of the importance to them of a religion/spiritual belief from 1-5. After 12 weeks at their final counseling session they will complete the 3 questionnaires for the last time, give another rating of the importance of religion/spiritual belief to them, and rate how they see their own recovery from –3 to +3.

Data analysis:

All results will be analyzed using Statistical Package for Social Scientists software. For Mini-SeRvE, overall means will be calculated for each individual, using reverse scoring for negative questions, eg. a score of 4 on agitation would be assigned a score of 2 for the calculation. This means that a low score on Mini-SeRvE always indicates worse mental being. Means of GAD and PSQ9 scores will also be calculated. A comparison of all these means between people who are under primary care, secondary care or no NHS care will be made using ANOVA. If there are significant differences, the other tests that follow here will be repeated in the 3 groups of people separately

Paired t tests would first be run to investigate the difference in means of Mini-SeRvE, GAD and PSQ9 for each individual between the first and final counseling sessions. This would allow initial calculation of sensitivity to change of Mini-SeRvE. A paired t test would also be calculated between initial Mini-SeRvE score and that from the second week, as an indication of test-retest reliability of Mini-SeRvE. Although it is not practical to include a control group in this study, these comparisons would also show the percentage of clients that improve during the course of the counseling, according to the 3 different measures used.

Correlations will then be run between Mini-SeRvE, GAD and PSQ9 scores and also between the different factors on Mini-SeRvE. From this, additional evidence for sensitivity to change of Mini-SeRvE might be found and the relationships between the 3 factors of Mini-SeRvE could be explored. This may lead to ideas about how these 3 concepts fit together within the overall process of personal recovery.

Finally, the global self-rating of recovery will be used. Correlation of this with overall Mini-SeRvE would be run. In addition, groupings of people with different experience of recovery could be compared, and the self-rating could also be used as an indicator of minimum detectable change. All of these will contribute to a fuller indication of sensitivity to change of Mini-SeRvE.

Burdens and benefits of study on participants:

All clients will be attending counseling sessions on a regular weekly basis, and will be routinely completing a weekly self-evaluation for monitoring purposes using GAD and PSQ9. Adding the Mini-SeRvE, the self-evaluation of importance of religion and their global self-rating of their own recovery would not be a major additional burden. Moreover, exploring the questions in Mini-SeRvE may actually be helpful for some people if they have not pondered these issues before. These could be a focus of positive discussion in the counseling session. Although it is possible that some may find the issues raised sensitive, they complete the evaluations before their counseling session, so there would be someone who could support them should they find these issues upsetting.

Limitations:

This study measures recovery over a relatively short period of time, when people with mental health problems often take many months if not years to recover. However, the priority given to positive mental health during the counseling makes it more likely that an improvement in Mini-SeRvE scores is seen over a short time. A further limitation is that specific diagnoses or a clinician's assessment of participants cannot be included within this study.

Qualitative phase

Methodology

Sample:

This would be a convenience sample of about 10 counselors working at the same counseling centre. These people have long experience of using GAD and PSQ9 as outcome measures. They practice personal centered counseling with a focus on promoting mental well-being in clients.

Study design:

A focus group will be held, in which counselors' experiences of using Mini-SeRvE will be discussed. Firstly, any problems emerging about ease of understanding or completing Mini-SeRvE will be noted. Then, a discussion will be invited about whether counselors found changes in Mini-SeRvE scores over time helpful to monitor personal recovery of clients. Comparison of use of Mini-SeRvE with use of GAD and PSQ9 would be sought. Possible use of Mini-SeRvE as a focus of discussion in the counseling session would be explored. The focus group session would be recorded with permission from the participants.

Data analysis:

Recording of focus group conversation will be transcribed and entered into a computer using NVivo software. It will be subjected to thematic analysis, using simple coding, so that common themes of counselor views can be identified.

Possible outcomes

The primary focus of this whole study is to confirm sensitivity to change and test-retest reliability for Mini-SeRvE. If this could be achieved, a separate larger study to compare Mini-SeRvE scores with a clinician's assessment would be possible. This could show how commonly service users struggle with personal recovery even when considered well by clinical staff. The secondary focus of the study is to study the relationships between the 3 subscales of Mini-SeRvE. This might lead to greater insight into the whole process. It might give new ideas about how spiritual care is best delivered and inspire the development of

completely new interventions to promote personal recovery. All of these could be evaluated using Mini-SeRvE. Thirdly, the experiences of counselors using Mini-SeRvE may provide further evidence of its face validity. It may encourage more routine use of Mini-SeRvE for clinical monitoring of personal recovery in service users and identification of their unmet needs.

Jo Barber September 2017

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