ENHANCING PRACTICE
(MENTAL HEALTH)

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Use of the Recovery Assessment Scale – Domains and Stages (RAS–DS) tool as an outcome measure in a Canadian outpatient mental health day program

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Occupational therapists working in the mental health field are positioned to provide clients with recovery-oriented services that align with the guidelines set forth by the Mental Health Commission of Canada (MHCC). The MHCC defines "recovery" as individuals "living a satisfying, hopeful, and meaningful life, even when there may be ongoing limitations related to mental health problems and illnesses" (Mental Health Commission of Canada, 2019). The recovery model views the client as a leader and places great value on lived experience and personal autonomy, as opposed to traditional approaches that rely on professional expertise to "fix" or "solve" problems (Mental Health Commission of Canada, 2019). When occupational therapists and mental health practitioners engage in regular reflection about power in therapeutic relationships and commit to intentional changes in their practices, this collaborative effort and vision works to create a mental health care system devoted to recovery-based services.

Historically, it has been difficult to measure the effectiveness of mental health services and clients' overall perceptions of recovery, as recovery is a very individualized journey. After interviewing over fifty people from Waterloo-Guelph (Ontario), Montreal and Quebec City (Quebec), Piat et al. (2009) found that recovery involved any of the following perspectives: finding a "cure," medication making the difference, "returning to my former self," "taking charge of life," or "evolving towards a new self" (p. 6-10).

Another challenge to measuring recovery involves choosing an assessment tool that accurately measures the construct of recovery. While most tools are largely symptom focused and thus measure only one aspect of recovery (Hancock et al., 2015), other assessment tools are specific to understanding only certain diagnoses (Beidas et al., 2015). In addition, tools that are discipline-specific often make it difficult to communicate results to both clients and other clinicians within the team. Financial costs, inadequate psychometric properties, and lengthy assessments are other reasons why assessment tools are not being used in mental health settings (Beidas et al., 2015). All these factors have the potential to create significant barriers to evaluating the effectiveness of mental health programs and services.

As occupational therapists at the Brantford General Hospital, we started a Quality Improvement (QI) initiative to determine if clients are, in fact, moving towards recovery through their participation in an outpatient mental health day program. In the community of Brantford, Ontario, adults (16+) living with a mental illness can participate in the Acute Day Treatment (ADT) program through a psychiatrist referral. During this 6-week program, clients work towards recovery through a combination of receiving psychoeducation, setting goals, practicing healthy coping skills, developing a balanced routine, and learning about community resources. The program operates Monday through Friday, and offers three open groups between 9:30am and 2:00pm, with regularly scheduled breaks. Groups are facilitated by occupational therapists, recreation therapists, and social workers, who also work collaboratively with clients in individual sessions to address specific needs and goals. A consulting psychiatrist is also available to clients, providing assessments and support as needed throughout the course of the program. Clients have consistently provided feedback about the ADT program's impact on their recovery journey; however, with the exception of patient satisfaction surveys, no evidence-based outcome measures were being used to evaluate clinically observable changes in clients' mental health recovery. Therefore, finding an evidence-based assessment tool to measure recovery over time became our primary objective.

Evaluating recovery outcomes in mental health day programs in Canada is largely understudied, and yet this knowledge is important as policymakers call for programs to offer recovery-oriented services. After reviewing current literature and watching a webinar hosted by the Canadian Association of Occupational Therapists (CAOT), we discovered a great deal of research had been done in recent years by occupational therapist Nicola Hancock and the University of Sydney, Australia, to develop a tool called the Recovery Assessment Scale – Domains and Stages (RAS–DS, ras-ds.net.au). The 38-item RAS–DS is the most recent version of the original 41-item Recovery Assessment Scale (RAS), which underwent rigorous studies and revisions to ensure it could be used as a "reliable and useful measure of recovery" (Hancock et al., 2016). Recent studies show that the RAS–DS has good psychometric properties (good internal and construct validity) and can be used to measure recovery changes over time (Hancock et al., 2015; Hancock et al., 2016; Scanlan, Hancock, & Honey, 2017; Scanlan, Hancock, & Honey, 2018).

The RAS–DS appeals to us for several reasons. Firstly, the RAS–DS is a self-assessment tool that promotes client-centeredness. When clients are positioned to guide the conversation about their mental health recovery, they are more likely to create goals that are personally meaningful to them. Secondly, the 38 items of the RAS–DS are divided into four domains and measure different aspects of recovery, including: "Doing Things I Value" (functional recovery), "Looking Forward" (personal recovery), "Mastering My Illness" (clinical recovery), and "Connecting and Belonging" (social recovery) (Scanlan, Hancock, & Honey, 2017, p. 2). Finally, the language of the RAS–DS is easy to understand and use by clients and practitioners. The RAS–DS typically takes between five to 15 minutes to complete, and 78% of clients rated the RAS–DS as "easy" or "very easy" to understand (Hancock et al., 2016). The assessment tool is also available in 13 different languages.

Staff of the ADT Program used the RAS–DS with clients on admission and again on discharge, collecting a total of 49 paired data sets over the course of several months. To determine if the data was statistically significant, we reached out to Nicola Hancock and the team at the University of Sydney for support with data analysis. Preliminary results showed statistically significant changes across all four domains of the RAS–DS and the total RAS–DS score from admission to discharge. Although the "Connecting and Belonging" domain showed statistically significant changes, this domain showed the smallest amount of change over time. This information helped us to identify areas of improvement for the program, such as the need for clients to better engage with community supports. We have since begun to host additional guest speakers and facilitate community outings with local agencies. For instance, the Brantford Public Library is one of six community connections that clients can access while participating in the program. The concept of connecting and belonging with others through doing and engagement in meaningful occupations is a significant component of the human experience (Hammell, 2014), which highlights one of the unique ways that occupational therapy can foster recovery. Our QI initiative has therefore helped to explore both the impact of the ADT Program on clients' perception of recovery and the usability of a tool like the RAS–DS in measuring recovery in an outpatient mental health setting.

Discussion Points and Recommendations

- The RAS–DS is a self-assessment tool that uses recovery-based language, and sets the stage for building programs and services focused on recovery
- Occupational therapists may experience an enhanced understanding of clients' recovery by adopting the RAS–DS into clinical practice
- Occupational therapists may be better able to advocate for recovery-oriented services using the data generated by the RAS–DS
- The RAS–DS may be used to appraise the impact of mental health programs, creating opportunities to address needs and gaps in care
- One of the potential limitations to the above recommendations could be that it may be difficult to utilize the RAS-DS with clients who experience cognitive deficits. Additionally, it is difficult to use the RAS-DS strictly for program evaluation purposes, as there may be confounding variables affecting changes in pre and post RAS-DS scores. For example, clients may be engaged in multiple programs or services that are supporting their recovery.

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