'Recovery' – towards integration into an Irish community mental health team

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Abstract

Objectives: We aimed to further our understanding of the concept of recovery by analysing comments made in small group discussions that occurred on a planning Away Day held by a community mental health team alongside service users and carers, which had recovery as its theme. The purpose of this was to reshape the structure and workings of the team.

Method: Five small groups, of approximately 10 individuals each, comprised of service-users, carers, representatives from voluntary organisations and mental health professionals were asked to discuss three questions related to Recovery.

Results: The commentary reflected previous qualitative research on the philosophy of recovery. Issues that were raised included defining wellness as independent to illness, constructive risk taking, the importance of social factors, medication issues and the importance of self-management and optimism. The comments subsequently went on to shape community mental health team service delivery.

Conclusion: Discussion and reflection between mental health professionals, service users and carers can lead to a change in attitude and practice in a well-resourced, fully multi-disciplinary community mental health team, within which both the biological and non-biological aspects of mental illness are accepted. The result has been an introduction of service changes which have helped develop a team that is more accessible and increasingly collaborative.

Key words: Recovery; Recovery model.

Introduction

"Recovery is a process; a vision; a belief which infuses a system...which providers can hold with service users... grounded on the idea that people can recover from mental illness and that the service delivery system must be constructed based on this knowledge..." *Anthony 2000*

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Recovery is not a service offered by mental health professionals and it cannot be clearly defined as a treatment or a model. Over recent years, qualitative research has described recovery as a journey that is affected by a complex array of disparate factors.[1] This provides us with a difficulty in conceptualising recovery – a philosophy that embraces efforts to decrease stigma, counter-discrimination, address poverty, foster self-help, lay out multiple paths to wellness and promote social equality.[1]

In Ireland, over the last five years there has been an increasingly eloquent and vocal critique of current service models from sections of the user movement. A number of reports established by service users suggest that their experiences of Irish mental health services reflect a personally disempowering model which places an overemphasis on medication and tends to be based outside an ethos of hope and recovery.[2-5] The commentary calls for a change in mental healthcare, observing that professionals have the potential to engage with service users in a collaborative manner within the philosophy of recovery.[2-5] This is reflected in The Mental Health Commission discussion document on recovery,[6] and *A Vision for Change*,[7] which includes several themes common to recovery, particularly the section on partnership in care.

Objective

Consideration of such changes within a system of health care requires a dynamic knowledge of the fundamental needs and sensibilities of the people the system is seeking to serve. Recognition of the gap between what is currently being offered by a system of care and what service users actually want can provide information and direction for change.[6,7]

The primary aim in this paper is to reflect on the needs and judgements of individuals within the local catchment area, with specific reference to brain-storming comments which were made in small discussion groups on an Away Day held by the community mental health team *(see Appendix 1)*, alongside service users and carers, which had recovery as its theme *(see Appendix 2)*. We relate these comments to our understanding of recovery as described in the evolving literature base and, in doing so, move toward clarifying what we mean when we refer to recovery.

Finally, on a pragmatic level, we show how we have incorporated suggestions made on the day into the day to day workings of the team, with the view that recovery does not only relate to rehabilitation services.[8]

Method

Five small groups, of approximately 10 individuals each, comprised of service-users, carers, representatives from voluntary organisations and mental health professionals were asked to discuss these three questions:

- What does recovery mean to you?
- What do you see as the challenges to recovery?
- What can be improved to make the service more recovery focused?

Headings reflecting their discussion were then presented to the participants in their entirety. These headings have been used in *Tables* in this paper along with discussion and a review of the relevant previous research on the subject.

Results

What does recovery mean to you?

Points offered by small discussion groups fell into three main groups; beliefs about self and recovery, beliefs related to illness and recovery and beliefs related to social functioning and recovery.

i) Beliefs about oneself and recovery:

- Self-care • Reclaiming personal power • A state of well-being
- Regaining self esteem • Having hopes and dreams
- Being comfortable with myself and accepted • Fulfilling potential
- Back to a better place • Rejoining of a separated jigsaw
- Living full and satisfying life • Process of change in a person's life
- Positive attitude • Completeness • Meaning in Life
- Content • Having a sense of security

Separate to illness, symptomatology or treatment, a clear focus on regaining a sense of self and empowerment was evident. These comments are reflective of the early literature on recovery with Anthony's assertion in 1993 that "recovery can occur though symptoms recur",[9] and more recently, the suggestion that 'wellness' and 'illness' may be considered independent variables.[10]

Correspondingly, it has been observed that individuals with mental health symptoms often find that they lose their 'selves' inside mental illness. A stage of recovering could be seen as re-conceptualising the illness as part of the self, not a definition of the whole,[11] indeed, it has been found that a correlate of favourable outcome in schizophrenia was the individual's ability to differentiate the self from the diagnosis and the illness experience.[12]

ii) Beliefs related to illness and recovery

- Understanding the role of medication • Learn to strengthen the positive role
- Managing symptoms as a little bit of me • Not to be phased by the illness
- Having control – drivers seat • Not being dependent on services
- Understanding illness and coping with stressors
- A process – learn from relapses • Right to make mistakes and learn from them

The views expressed reflect the fact the groups were selected from mental health professionals, carers and service users who were well engaged by the service, and had received considerable education on biological theories of mental illness. They do, however, indicate that a crucial prerequisite for recovery is not merely specialist professional intervention, but for the person to find a way of understanding their experience, therefore establishing a sense of personal value.[13]

Giving individuals a coherent framework in which to conceptualise their problem is an important factor in reducing demoralisation and in inducing hope or the expectation of improvement.[14] (A similar viewpoint has also been used in making a case for using diagnosis in psychiatry[15]). This particular form of psycho-education also enables individuals to fully participate in treatment partnerships in which they can make autonomous decisions with the subsequent increased personal responsibility for the consequences of these decisions.[16]

This will to take responsibility and the 'right to make mistakes' was apparent in the group discussion, reflecting the concerns that have been voiced relating recovery to risk.[17] However this risk does not necessarily need to be borne by one individual – in current clinical practice often the doctor – Roberts and Wolfson,[10] commented on this "shift from risk avoidance to risk sharing", with the conviction that risk is "inevitable and healthy" and necessary for genuine progress.

Risk avoidance at all cost may cause a rupture in the service provider/user relationship with its own inherent dangers, in relation to disengagement.[17] It is also of note that much can be learned from relapse and indeed this is an important component of the Wellness Recovery Action Plan (WRAP) as seen below.[18]

iii) Beliefs related to social functioning and recovery:

- Secure accommodation • Gainful employment
- Journey to function in community where one belongs
- Functioning better day to day • Improved lifestyle and choices
- Feeling part of the wider community • Empowerment
- Support • Belonging

The groups envisaged recovery as a profoundly social process and emphasised both the importance of meaningful adult life roles and that mental health services should have a significant focus on active citizenship.

Employment is known to play a significant role in recovery, particularly in the areas of social, existential and spiritual growth as well as the more obvious financial benefit.[19,20]

Many individuals feel that their job contributes to the definition of who they are, embeds one in a social matrix separate to one's home life,[21] and also facilitates the possibilities of further lifestyle change such as finances for leisure pursuits and housing – access to suitable homes, with all the positive connotations that the word suggests, is of major significance in recovery and is increasingly a factor with the ongoing movement of de-institutionalisation.

What do you see as the challenges to recovery?

These fell into two categories: concerns related to illness and the service available and concerns about the general public and social disadvantage.

i) Concerns about illness and the service:

- The Medical Model • Role of patient • Clarity and therapeutic relationship
- Disempowered staff and clients • Service user not involved in care plan
- Non-compliance • Poor Insight • Lack of evidence base
- Symptoms of illness • Medication • Role clarification/conflict/rivalry
- Lack of counseling • Willingness to listen • Resistance/power

It is apparent that some view the 'medical model' as a barrier to recovery and that the two models "stand in significant tension with each other".[10] While the thrust of evidence-based and biological psychiatry has empowered the professional with invaluable insight into the disease model, in

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our discussion it was suggested that the manner in which this knowledge is delivered is partially inadequate to meet the needs of the service user.

Recovery is seen as different to a biopsychosocial model. In the ethos of recovery, the service-user is seen as both active and responsible,[18] working with and alongside the professional. Commentary has suggested that a different use of language is required to reflect this and also to emphasise this collaborative approach.[23]

The use of the term 'patient' has been criticised by individuals who have taken exception to its inherently passive connotations (waiting to be 'treated'), with preference given to other terms, such as consumer or service-user – terms that may offer identities that enable people to reclaim some sense of responsibility for their situations. We are aware that this is not a universal opinion and has been the topic of recent debate.[24]

It was clear that for some the experience of taking medication, side-effects, lack of pharmaco-education and the fundamental implication of taking medication for what they may see as 'emotional' problems can actually be a more distressing experience than that of the disorder itself.[25]

From our discussions it was agreed that doctors should discuss both the benefits that medications offer and their limitations,[26] while also remaining aware of the fact that some patients may improve and remain improved without the use of prescribed drugs.[25]

The commentary from the groups is not, in our opinion, indicative of anti-psychiatry rhetoric (and, indeed, we accept the biological nature of mental illness), and does not equate with an abandonment of what medicine has to offer in terms of managing symptoms and illness, but is representative of a process of reclaiming the whole person from the partiality of a purely medical definition.

ii) Concerns about the general public and social disadvantage:

- Lack of education • Public attitude, stigma • Lack of meaningful work
- Culture and environment • Ignorance
- Fear of stigma, relapse and the unknown
- Tradition • Everyday stressors • Fears and anxieties from all bodies
- Stigma • Celtic Tiger

Further discussion focussed on the areas of stigma and social exclusion. Stigma has been referred to as the most formidable obstacle to future progress in the arena of mental health,[26] and there is compelling evidence to reinforce the detrimental effects that the groups referred to.

As alluded to earlier in this article it has been found that stigma was an independent and significant predictor of self esteem. This may suggest that reducing social stigma may help reduce the internalised stigma that restricts the ability of some service users to define 'a self' apart from their diagnosis.[11]

Socially, there are high rates of parents with severe mental illness losing custody of their children, of unemployment amongst those with severe mental illness and in the number of people who spend their lives in segregated settings rather than as integrated community members.[27]

Further, higher levels of perceived stigma at the start of antidepressant treatment predict poorer compliance with medication,[28] and it has also been found that concerns about stigma during an acute phase of illness in individuals with bipolar disorder are significantly associated with poorer social adjustment seven months later.[29]

Prejudice, ignorance and discrimination have been identified as the three components of stigma which need to be addressed,[30] and we will allude to these later in this paper.

What can be improved to make the service more recovery focused?

As can be seen in the group discussions, service-users, because of their experiences, bring different attitudes, motivations and insights to mental health treatment. These important perspectives display the need for their direct participation in treatment planning, evaluation and research activities in creating a system that focuses on recovery.[1] The following comments, made at the end of day summary, have particularly shaped our current practice.

i) Developing self-management plans:

- Allowing patient to make decisions for themselves
- Identify strengths and abilities • Self help groups
- Partnership – working with client • More input from patient in their care
- Autonomy • Learn from positive achievements

(i) Developing self management plans

Both professionals and service-users were vocal on the importance of self-management. Studies show that self-management, or a person's determination to get better, manage the illness, take action, face problems, and make choices, can facilitate recovery from mental illnesses.[1]

It was thought that an area of focus should be on programmes that develop the confidence and motivation of patients with ongoing symptoms to use their own resources and strengths to take control of their lives. At initial contact individuals who present to the service are assisted in developing an understanding of the origins of their distress using the Stress Vulnerability Model,[31] and following the Away Day the service has been in the process of introducing the Wellness Recovery Action Plan (WRAP),[32] developed by Mary Ellen Copeland and extensively explained on her website, videos and workbooks.

It describes how individuals can facilitate their own wellness by developing a daily maintenance plan, identifying triggers to relapse and formulating an action plan for use when they identify early warning signs of relapse. WRAP also encourages development of a crisis plan, which may allow an individual to keep control in times of crisis, as well as a post-crisis plan, which enables professionals and service users to reflect on how a crisis was managed. Empirical research is possible with WRAP due to the availability of a pre-test post-test instrument developed by the model's creator and there is an evolving evidence base for its use.[33] Using DVDs and workbooks we have introduced WRAP in both individual and group formats. Service users have identified these groups as particularly empowering and professionals have identified them as a powerful tool for collaborative working.

ii) Outpatients and care-coordination:

- NCHD rotation • Lack of choice • Partnership – working with client
- Choice of doctor • Work as MDT

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(ii) Outpatients and care co-ordination

Qualitative research within the catchment-area has demonstrated dissatisfaction with outpatient clinics,[3] and this was again apparent in the group discussions. Service-users have raised the issue of frequent NCHD rotation and their perception that doctors focus overtly on symptoms of illness to the exclusion of other aspects of an individual's life.

We have incorporated good practice guidelines which identify that all individuals referred to a mental health service should have a comprehensive assessment addressing medical, psychological, occupational, economic and social needs[26] with ongoing work alongside the member of the team who is considered the most appropriate care coordinator. Along with liaising with the consultant, GP, family members and with other members of the team, the care-coordinator may assist individuals in linking in with main stream work and training within the community – this is facilitated by strengths-based recovery care plans which have been developed by the team.

The system borrows from the business world by using a 'pull' system for review at outpatient clinics, where individuals are seen by doctors in time and when required, rather than the inefficient 'push' system of traditional outpatient clinics and this is in keeping with the view that psychiatrists should be "on tap and not on top."[34]

Service users are facilitated with earlier discharge from the service with an agreement that should they require future input they can re-refer themselves directly to a mental health professional who knows them thus gaining a sense of control of their management and using the service as a "springy safety net".[10]

It was apparent in discussion that individuals want a service that they can contact when they need it, without necessarily becoming occupied with long term involvement and monitoring, however well intentioned. The use of educational and recovery groups help ensure service users are making informed decisions.

iii) Focus on stigma and social inclusion:

- Believing in people
- Allowing patients to make decisions for themselves
- Education

(iii) Focus on stigma and social inclusion

Research suggests that stigma should be tackled with a three-pronged approach, at personal, local and then national levels.[35] It was observed that any fundamental change in the dichotomous 'us and them' thinking that underlies stigmatisation must start with the shift in the interpersonal dynamic in relationships between service-users and the professionals that treat them, reflecting the evidence that viewing a mental health professional as an experienced and committed person who believes in you and your future has a major impact on outcome.[36]

As recommended by the WHO, well-planned public awareness and education campaigns which may reduce stigma and discrimination, increase the use of mental health services, and bring mental and physical health care closer to each other have been discussed with view to implementation.[37]

The importance of work and employment in recovery has led to a focus within the team in supporting individuals to returning to work and training. While acknowledging the role of stress in relapse, the benefits of work are emphasised and all efforts are made to support employers and employees.

iv) Reflective practice:

- Balance between care giving and letting go
- Identify strengths and abilities
- Learn from positive achievements
- Working as a multi-disciplinary team
- Empowerment
- Reflective practice
- Encouraging

(iv) Reflective practice

Within the team there has been a marked change in communication since the integration of the values of recovery, with roles clearly defined and a distinct respect for the views of all, particularly the service user. We have endeavoured to provide a team environment where there is a culture of realistic respect, collaboration and trust within which decisions are robustly reviewed and clinical concerns are openly discussed in a group setting.

Where an individual makes a request that professionals feel may not be in their best interest, significantly more time is put into engaging, empowering and supporting the individual to make a well informed choice, and the service supports the individual in the consequences of that choice. Regular communication and an awareness of risk, ensures this is carried out safely.

On the occasions where individuals are detained under the Mental Health Act, in keeping with recent recommendations,[38] ongoing reflection and discussion during and after hospitalisation is used to inform further management.

v) Hope and optimism:

- Carrying/inspiring hope
- Believing in people
- Encouraging
- Have belief and confidence in client
- Having dreams and hopes
- Instilling hope
- Positive attitude

(v) Hope and optimism

Finally, and most importantly, for the service user, being met with hope and optimism, especially at initial contact is of central significance.

In our practice we hope to keep in mind the dimensions of "hope inspiring relationships",[20] valuing people as individuals, accepting and understanding, believing in their abilities and potential and accepting failures and setbacks as part of the recovery process.

Limitations of design

The groups were comprised of service-users and staff, the majority of whom had received considerable education around the biological nature of mental illness and, as such, they may not have been an entirely representative sample. Conversely previous recovery research has been open to the criticism of over-representing those with an anti-psychiatry viewpoint. This is an ongoing issue and despite the mounting qualitative research that emphasises the importance of hope, autonomy, self determination and patient-participation, evidence for recovery-based approaches, in the form of well-controlled, representative and quantitative study, is not well developed.[39]

Conclusions

This paper has described how an annual sector planning

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day was used to facilitate greater emphasis on recovery principles within a community mental health team.

In Ireland, there may be a perception that recovery and wellness is, at best, the remit of rehabilitation psychiatry and, at worst, an incorporation of areas of anti-psychiatry. This paper shows how discussion and reflection between mental health professionals, service users and carers can lead to a change in attitude and practice in a well-resourced, fully multidisciplinary community mental health team, within which both the biological and non-biological aspects of mental illness are accepted.

The result has been an introduction of service changes which have helped develop a team that is more accessible and increasingly collaborative. Ideas borrowed from areas such as New Ways of Working,[40] have proved useful in aiding the introduction of these services.

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Appendix 1: Description of the Service

The Loughrea-Athenry Community Mental Health Team is a well resourced community mental health team, with a complete multidisciplinary team. Monthly service development meetings are held, which are attended by service user representatives. The team receives ongoing feedback from service users and carers on the Service. A team training day is held annually and is attended by service users and carers. The entire team meets with GPs in the area on an annual basis.

Appendix 2: Description of the Day

The proposal to base the Annual Away Day for the Loughrea/Athenry Mental Health Service on the concept of 'Recovery in Mental Health' was decided at a team sector development meeting following a presentation by the team's social worker on recovery.

Planning was carried out by the team's occupational therapist and social worker with an extensive literature review on the concept of recovery and through contact with voluntary sector organisations focused on recovery. Representatives from voluntary sector organisations were invited to attend the day. These included Schizophrenia Ireland, Western Alliance for Mental Health and the Irish Advocacy Network.

The Annual Away Day has been running for 10 years and its attendees have included multi disciplinary team members from both the inpatient facilities and those within the community based team. Service users and carers were invited to attend the day in keeping with recovery principles, ensuring that service users' and carers' voices are heard.