Perspective

Recovery from mental illness: changing the focus of mental health services

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Abstract

The concept of recovery entered the lexicon of the mental health services in the 1980s following the publication of a series of studies and personal narratives which demonstrated that the course of mental illness was not always one of inevitable deterioration and that people diagnosed with severe mental illness could reclaim or recover meaningful lives.[1] For a long time, recovery was not thought possible by many family members, service providers and researchers. However globally, specific policy and clinical strategies are being developed to implement recovery principles although key questions remain. In fact, the possibility of recovery is still debated by some. In this paper, we include information about the recovery model and the medical model; we provide evidence for recovery and document changes in mental health practices and policies incorporating recovery as the guiding principle. We also attempt to address the debate as to whether recovery is an evidence based practice. We propose that evidence based practice should be complementary to value-based and narrative-based practices and we suggest an integrative model that maximises the virtues and minimises the weaknesses of each practices *(see Figure 1)*.

Key words: Recovery; Evidence based practice; Narrative based practice; Value based practice; Assessment of Recovery; Recovery model; Medical Model; The Wellness Recovery Action Plan (WRAP); The Future of Recovery.

Introduction

The concept of recovery is rooted in the simple yet profound realisation that people who have been diagnosed with mental illness are human beings.[2] Until recently, the general belief is that, people with mental illness do not recover, will always remain a burden on the society and must be taken care of rather than be encouraged to become independent, contributing members of the society.

Personal recovery has been defined as being able to occur in the presence of ongoing symptoms but involving a way of living a satisfying, hopeful and contributing life even with limitations caused by illness.[3] There is a reconnection not just with others but with a spiritual dimension of the self.[4] Globally, the promotion of recovery has recently been recognised as an organising principle for the transformation of mental health services. Recovery-oriented services replace the myth of chronicity and dependence with a message of individualism, empowerment and choice in the context of collaborative relationships with service users.[5]

One thing that stands out from the literature is that developing a truly recovery-focused service requires a significant paradigm shift both in people's conceptualisation of mental illness, and thinking about how people who experience mental health problems should be cared for. Emphasis moves from service delivery based on a paternalistic dependency model of care to one of enabling service users to take control and to reach their full potential in terms of both health and social gain.[6]

The best way to conceptualise the recovery model is by summarising the traditional medical model and highlighting the distinguishing features of the recovery model.

The Medical Model

This model proposes that it is useful to think of abnormal behaviour as a disease, it clearly represented progress over earlier models of abnormal behaviour. The emergence of the medical model brought great improvements in the treatment of people who exhibited abnormal behaviour. As victims of an illness, they were viewed with sympathy rather than hatred and fear. Although living conditions in asylums were often deplorable, there was gradual progress towards more humane care of the mentally ill. It took time, but ineffectual approaches to management eventually gave way to scientific investigation of the causes and treatment of psychological disorders. In summary, the underlying goals of the medical model as described by Fisher[7] are stabilisation, maintenance, and an increased level of functioning.

The Recovery model

In this model, the distinguishing feature is that the primary aim of psychiatric care is to enable service users with mental health difficulties to function within their individual social context, irrespective of their symptoms, and to help them live a personally fulfilling and meaningful life. Hence, recovery-oriented mental health services are supposed to flexibly adapt to the service users needs, and focus on their strengths rather than on their deficits or dysfunctions. Another distinguishing feature is that while professionalised clinical approaches tend to focus on improvement in particular symptoms and functions, and on the role of treatments; service user approaches tend to put more emphasis on peer support, empowerment and real-world personal experience.[8,9]

Although the recovery model has been gathering support in the international literature, objections to this approach have recently been raised among some mental health professionals. Pointing out that the recovery model is subjective,

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Figure 1: An integrative model that maximizes the virtues and minimizes the weaknesses of both the recovery and medical model

not data-based or scientific, Peyser[10] suggested that it may in fact interfere with treatment. He was of the opinion that psychotic illnesses and similar illnesses can subvert the thinking process to the point that the service user is taken over by the disease. Munetz and Frese[11] observed that many service users are so disabled with mental illness that they do not have the capacity to understand that they are ill. Giving such service users the right to make decisions about their treatment is tantamount to abandonment.

Adopting recovery principles is not about relinquishing the role of a clinician. It is about making every effort to eliminate the use of coercive treatments to the greatest extent possible. Service users must be treated with compassion and respect during acute or incapacitating episodes of mental illness. They should be offered choices to the greatest extent possible with regard to their treatment plan. As they progress along the road to recovery, their growing capacity for autonomy should be respected, eventually to the point where decisions are made by the service users supported by their professional team who provide choices, information and support. Thus service users irrespective of the severity of their illness can benefit from the client centred recovery model.

Mental health interventions should be designed to be empowering, enabling the service users themselves to take responsibility for decisions about their lives or nominate someone of their choice in their crisis management plan to assist in making decisions on their behalf when severely unwell. Recovery can thus be viewed as one manifestation of empowerment. Fisher proposed a number of principles of how people recover and identifies the characteristics of people in recovery.[7] Four stages of recovery have been described as hope, empowerment, self-responsibility, and establishing a meaningful role in life.[12]

The recovery model also focuses on the continuous process of change inherent in all people, conveying the meaning of the experiences through metaphors. People who have recovered from mental health problems often report that very individual things helped them, things that may have never been scientifically investigated.[13]

Recovery is it evidence based?

We define evidence-based practice (EBP) as a systematic approach to problem solving for healthcare providers, characterised by the use of the best evidence available for clinical decision making. Under this concept, scientific evidence is required for treatment approaches which includes psychological, sociological, and biological evidence. At present, recovery from mental illness is not considered an 'evidence-based practice' because there have been no randomised, clinical trials with 'proven' results. Yet, consumers, providers, payers, and funders of private healthcare are looking for definitions, information and studies which tell them more about recovery, what it is, how it takes place, and how it can be achieved. There is also a debate as to whether recovery is a process or an outcome – or perhaps both.

As the initiative to develop evidence-based practice is moving forward, there has been a vigorous discussion about whether, and to what degree, EBP and the recovery model are compatible. Evidence-based practice relies on empirical evidence regarding the effectiveness of treatment and services for mental illness. What constitutes 'evidence' depends on the framework used to evaluate practice and outcome.

While evidence-based practice emphasizes external scientific reality, the recovery model stresses the importance of the phenomenological, subjective experiences and autonomous rights of persons who are in recovery. Clearly, there may be conflicts between patient choice and evidence for the best treatment but competent people can make wrong decisions. In the recovery model, treatment decisions are not made entirely on factual, scientific grounds alone. Rather, treatment decisions should involve both medical facts and personal choices based on values. Evidence-based practice can identify alternative possible treatments, an outcome probability distribution of efficacy and adverse effects for each treatment option. Service users' decisions about treatment will be more likely to reflect their values than will decisions by treating clinicians, even when clinicians attempt to determine service users' preferences. Thus treatments based on evidence-based practice may differ from treatments that are based on the recovery model insofar as they reflect different judgments of the value of various treatment outcomes by service providers and service users.

However, there is a wealth of evidence that recovery does take place, that it can be theoretically described in model and narrative, that it can be taught, and that it can be practiced. There are also some preliminary efforts to measure recovery.

The classic outcome study is that of the 32-year longitudinal study of patients from the Vermont State Psychiatric Hospital.[14] Patients who had been hospitalised continuously for six years participated in a rehabilitation programme and were released in a planned process with community supports in place. 262 (97%) of the original patients were traced. 34% of the people living with a diagnosis of schizophrenia experienced full recovery in both psychiatric status and social functioning (ie. no current signs or symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and no indication of having been hospitalized for any kind of psychiatric problem). An additional 34% of the people were significantly improved in both areas.

A selection of patients hospitalised in Maine during the same period of time was matched to the Vermont cohort by age, sex, and diagnosis and outcomes were compared between the two groups.[15] It was generally found that

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Vermont subjects were more productive, had fewer symptoms, and displayed better overall functioning and community adjustment. The rehabilitation programme was considered the reason for this.

An extreme view suggests that modern medicine lacks a metric for existential qualities such as inner hurt, despair, hope, grief and moral pain which frequently accompany, and often indeed constitute, the illnesses from which people suffer.[16]

Narrative-based practice (NBP)

Narrative-based practice focuses on the art of story-telling. For any individual the same story could be told from different perspectives. The story of Ben Silcock entering the lion's den at London Zoo is a good case to consider. It was initially reported as a suicide attempt (Horror in the Lion's Den, Daily Express, UK, January 1, 1993). Ben's father expressed his frustration and he gave a painful account of Ben's poor response to "patchy and inconsistent treatment for schizophrenia – which community, what care? Both have failed Ben". (Sunday Times, UK,10th January 1993). Ben offered his own perspective in 1994, saying: *"I want to try to shed a little light on the experience of madness from the point of view of the afflicted. So often we get descriptions of madness from psychiatrists who can only express their observation in a clinical way, with little consideration for the patient's soul… maybe we should take a breakdown as a sign that our ways of living need to change."*

A narrative-based practice attributes significance to each account, without seeking to reduce one to the other. *"The subjective, personal, patient story and the interpretative, scientific, medical story are not translations of each other but independently co-existing narratives"*. [17]

Value-based practice (VBP)

Values-based practice is a skills-based approach to working with complex and conflicting values in health and social care.[18,19] The approach is relevant to compulsion essentially because compulsion involves a direct conflict of values between the person concerned and everyone else. Central to VBP are guiding principles, code of practice and mental health acts because they provide a framework of values for balanced decision-making. By nature, compulsion is prone to misuse than most other interventions. Hence the need for safeguards. Safeguards in themselves, however, will not ensure good practice. What is needed, in addition, is the positive approach to recovery and the development of the skills of self-management.[20] Thus, the law tells us 'what to do'; the code of practice tells us 'how to do it'; and the guiding principles, set within a values-based approach, guide us in applying the law and code of practice in the particular circumstances of each individual case.[20]

While the narrative- and evidence-based approaches or even values-based practice appears to be in conflict, or even in competition, the view that we are advocating here is that they are necessary and complementary companions especially in the recovery movement *(see Figure 1)*.

Active adult learning

Active adult learning is defined as the method by which students are provided with opportunities for meaningful talk, listen, write, read, and reflect on the content, ideas, issues and concerns of an academic subject.[21] Active learning derives from two basic assumptions; firstly that learning is by nature an active endeavour and secondly that different people learn in different ways.[21] It is about making teaching and training learner-focused and this involves all aspects of the learning process, ie. the learners' own needs, abilities, learning styles, existing skills and experiences. Traditional teaching approaches have tended to be teacher-centred, with the teacher directing learning. Active learning occurs when learners have opportunities to apply the skills and knowledge they are seeking to develop.

The Irish Policy

The Irish *Vision for Change 2006* mental health policy document[22] proposes a framework for promoting mental health and a recovery approach to inform every level of service provision. In addition, a recovery-focused approach to the treatment and care of service users is one of the standards identified in the *Quality Framework for Mental Health Services in Ireland.*[6] The Mental Health Commission of Ireland reports that its guiding documents place the service user at the core and emphasise an individual's personal journey towards recovery.[6]

Recovery is a concept that was introduced by people who have reclaimed their lives following mental health experiences and this movement has gained momentum in recent years. The main themes identified with this approach were the importance of a satisfactory sense of personal identity, coping with symptoms and getting better irrespective of the presence or otherwise of an enduring mental illness.

The Wellness Recovery Action Plan (WRAP)

The Wellness Recovery Action Plan (WRAP) was developed by Mary Ellen Copeland.[23] She identified five concepts required for recovery. They are hope, personal responsibility, education, self-advocacy and support.

She defined the WRAP as a self-management and recovery system designed to maintain wellness, decrease symptoms, increase personal responsibility and improve quality of life. The self-designed plan teaches service users how to keep themselves well, to identify and monitor their symptoms and to use simple, safe, personal skills, supports, and strategies to relieve these symptoms.

WRAP can be used along with any other treatment scenario that the service users choose for themselves.[23] In Ireland, independent healthcare providers are funding wellness and recovery programmes based on the WRAP. The Irish Mental Health and Recovery Education Consortium has been established in Ireland to help develop and deliver a facilitated learning programme on mental health recovery and WRAP in the country.

Global adoption of recovery principles

Globally, the trend in the delivery of mental health services is to embrace recovery as the underlying principle in the delivery of care. A review of the literature suggests that the New Freedom Commission on Mental Health has proposed to transform the mental health system in the US by shifting the paradigm of care from traditional medical psychiatric treatment toward the concept of recovery, and the American

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Psychiatric Association has endorsed a recovery model from a psychiatric services perspective.[24,25]

Mental health service directors and planners are providing guidance to help state services implement recovery approaches.[26] Some US states such as Wisconsin and Ohio, already report redesigning their mental health systems to stress recovery model values like hope, healing, empowerment, social connectedness, human rights, and recovery-oriented services.[27] In Canada, areas such as the Ontario region, have adopted recovery as a guiding principle for reforming and developing the mental health system.[28]

In New Zealand, all mental health services are required by government policy to use a recovery approach, mental health professionals are expected to demonstrate competence in the recovery model.[29] Australia's National Mental Health Plan 2003-2008 states that services should adopt a recovery orientation.[30] The National Institute for Mental Health in England has endorsed a recovery model as the guiding principle of mental health service provision and public education.[31] The Scottish Executive has included the promotion and support of recovery as one of its four key mental health aims and funded a Scottish Recovery Network to facilitate this.[32] A 2006 review of nursing in Scotland recommended a recovery approach as the model for mental health nursing care and intervention.[33]

Assessment of recovery

A number of standardised questionnaires and assessments have been developed to try to assess aspects of the recovery journey globally. Questionnaires have been designed such that they assess the degree to which persons in recovery, providers, family members, advocates, and mental health directors believe that their various establishments engage in a variety of recovery oriented practices. These include the Recovery Enhancing Environment measure[34], the Stages of Recovery Instrument[35] and numerous related instruments.[36]

Conclusion

Recovery-based service delivery is increasingly becoming the global norm. All clinicians must understand the implications for their own service users. In order to promote the recovery approach and recovery-oriented practice within any mental health service, it is vital that all the stakeholders become active participants. Funding is required in Ireland for studies on recovery within our services and specific population. Service users and their carers must be actively involved at all levels in the planning and delivery of their care. We propose the integration of evidenced-based practice, narrative-based practice, values-based practice and active adult learning principles to enable recovery of service users and services.

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