Module:

Mental Health in the Community

Week 4: Psychosocial approaches to care in the community

Topic 4: The recovery paradigm (Part 3 of 3)

Lecture transcript

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In part 1 of this lecture, we defined personal recovery and differentiated it from clinical recovery. In part 2, we described some examples of recovery promoting interventions. In this part, we will discuss recovery oriented mental health services, which means whether mental health teams operate within the paradigm of recovery.

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When we talk about recovery oriented mental health services, we don't simply mean offering recovery promoting interventions such as peer support. Recovery oriented mental health services mean that all professionals, for example, psychiatrists, social workers, psychologists, regardless of the specific service they offer, for example, treatment services or rehabilitation services, will work within a set of values. These values are supporting personal recovery. The several services offered within the mental health system should have as primary goal supporting personal recovery. For example, a psychiatrist prescribes medication to manage symptoms, but symptom management is not the ultimate goal. Symptom management will help the person to feel better so that they can work towards the achievement of a meaningful life. This is closely connected with the second value, which is supporting the person's goals. The role of the professionals is not imposing meanings of recovery or assumptions of what matters in life. The person receiving services is the one defining their goals.

The second value is also connected with the third value. In a recovery oriented mental health service, professionals work in a way that acknowledges that people receiving services are responsible for their lives. The role of staff is not to fix people, but rather to help them in their recovery journey.

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Recovery-oriented practice means that staff, clinical or other, work and relate to people who use services in a way that promotes growth and empowerment so that they can achieve their full potential. In the past decade, training programmes to promote recovery-oriented practices were developed. In this lecture, we will focus on Refocus.

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Refocus was a five-year programme of research. It ran between 2009 and 2014. It was led by King's College London. Refocus was aimed at improving the recovery orientation of mental health services in England. The refocus intervention resulted from this programme of research. The goal was to train mental health workers to embed a recovery approach into their practice. The refocus intervention has two components. Recovery promoting relationships, which means how staff interact with service users and the working practices: tasks and activities professionals and service users can do together to promote recovery. There are three main working practices. Understanding values and treatment preferences, assessing strengths and supporting goal striving. The two components, relationships and working practices are interconnected. The successful implementation of the working practices will depend on the quality of the relationship. Because as important as what we do, it's how we do it.

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First of all, it is important to emphasise that service providers work *with* the person rather than *for* the person. The refocus intervention promotes the use of coaching as an interpersonal style. This interpersonal style will help staff members to apply the three working practices that will be discussed in the next slides. The role of the coach is to encourage the person to think about their own solutions. Coaching is not aimed at fixing problems. Although the coach guides the individual to use their strengths and resources, the person being coached is accountable for their life.

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If the main objective of mental health services is to promote personal recovery, it is crucial that the person's values and treatment preferences are assessed and understood. Therefore, this information should be recorded in the clinical information system. What does understanding values and treatment preferences mean? It means learning about what matters to people, and what gives purpose to their life. Learning about people's life history, including significant positive and negative life events. It involves learning about the person identity beyond being a patient. It may involve learning about their identity, for example, culture, ethnicity, spirituality. Staff members may support individuals to develop a personal narrative. This may involve encouraging the person to reflect on what influenced them to be

who they are. Understanding treatment preferences involves learning the type of help the person would like to have from mental health services and other sources. It is very important that staff respects boundaries regarding what the person wants or does not want to share. Staff should give individuals the opportunity to discuss areas they wish, even if it involves sensitive topics.

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Bird and colleagues developed an interview guide to help staff understand values and treatment preferences. The values and treatment preferences interview guide. Professional and client have a conversation about the topics on the interview guide, but there is no need to follow the same order. In this slide, you can see part of this interview guide including questions about cultural identity for example race and culture, and questions about religion and spirituality. The full interview guide can be found in the refocus manual which is freely available. It is included in the reference list at the end of this lecture.

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The second working practice is assessing the person's strengths. This practice aims to gain a holistic understanding of the person. Since recovery means more than just treating illness, the assessment of internal and external resources is fundamental to help people to achieve personal recovery.

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On this slide, we can see an example of a strengths worksheet. In this worksheet, clinicians assess the client's current situation, their desires and aspirations, and also their personal and social resources. This exercise is done for different areas, for example, daily living situation as well as financial and occupational circumstances. Please pause this lecture and take some time to read it before continuing.

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The third working practice is goal-striving. Goal-striving is supported by coaching. As mentioned previously when discussing the recovery promoting relationship, coaching is an interpersonal style which avoids a paternalistic approach. Staff members work within the GROW framework which involves the following discussion. Goal, including questions such as, where do you want to be? What do you want to happen? What it will be like when you reach the goal? Then the reality is discussed. For example, with the question, what is the situation now? Then clinician and client explore options. What's possible? What are the options to get closer to the goal? And then there is a wrap up where clinician and client agree on next steps.

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Approach goals are preferable than avoidance goals. For example, “I would like to use other strategies besides medication to manage my illness”: this is an approach goal and it's preferable than an avoidance goal (I want to reduce my medication). “I want to dance again”, would be in general, more motivating than “I want to lose weight”. An avoidance goal

involves escaping something which some individuals may consider negative. For example, medication. An approach goal involves a positive change towards what the individual would consider a better life. Envisioning a better life is usually more motivating than focusing on avoiding negative things.

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But goal-striving needs to be done sensitively. Since this may lead people to remember situations where they failed or perceived they failed in achieving goals, as we discussed in the context of Illness Management and Recovery. A trusting relationship between service user and staff member is essential if the goal is to encourage people to be able to talk about very personal and sometimes private hopes and dreams. Questions asked can include “what would make your life better?”; “How would you feel about trying something new?”; “What might that be?”; “Is there something you have always wanted to try or do but never had the chance to?”; “Will now be the time to try it?”.

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But what is the evidence for REFOCUS? Let's talk about two articles published in the Journal, The Lancet Psychiatry. One published in 2015 by Mike Slade and colleagues reporting results of the REFOCUS intervention in the UK and the other published by Meadows and colleagues in 2019, reporting results of the adaptation of REFOCUS in Australia.

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Slade and colleagues compared outcomes for people with psychosis, either receiving the refocus intervention plus treatment as usual or treatment as usual only. The teams delivering services were community-based and were multi-disciplinary. For example, teams providing long-term support to patients with complex needs, high support forensic teams, and assertive outreach teams. The teams assessed health and social needs and provided care coordination.

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Although the primary end point related to differences between service users of the two groups in terms of personal recovery was not significant. The results suggested that high team participation would be significantly better than low participation in terms of staff rated recovery promoting behaviours, and patients rated interpersonal scores. The authors defended that the failure of the intervention to improve the primary outcome of recovery may had to do with implementation problems. According to the authors, more implementation strategies are needed, especially in terms of leadership and organisational culture. It is crucial that organisation culture embeds expectations of partnership-based relationships between staff and service users and of working practices that focus on service users' values, treatment preferences, and strengths. Furthermore, embedding a recovery orientation culture may require change at the organisational level rather than at the team level only. Also, many participants had been using services for more than 15 years. So these individuals could probably have deep-rooted ways of interacting with staff. Changes may be more difficult to implement in these circumstances. Also, a trusting relationship can take more than one year to develop, which was the timeframe of the intervention.

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The REFOCUS-PULSAR, and PULSAR is the acronym for Principles Unite Local Services Assisting Recovery is an adaptation of the UK's refocus intervention in Australia. Meadows and colleagues carried out a stepped-wedge cluster RCT. This means that all sites received the intervention, but the time of when the intervention was received differed between sites. One hundred and ninety staff members were trained in the REFOCUS-PULSAR intervention. Staff members who received training pertained to multiple disciplines, but senior medical staff was less engaged in the team-based training. Recovery measured by the questionnaire about the process of recovery was significantly higher in the intervention group but the effect size was small. Despite the small effect size, the significant difference is encouraging since small effects are common in pragmatic trials, which means trials assessing effectiveness of interventions in real life conditions.

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In Part 3 of this lecture, you learned about the values underpinning recovery-oriented services and also about the REFOCUS intervention to train staff in recovery promoting relationships and in recovery promoting working practices.

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Thank you for listening to this lecture. I hope it was of interest to you. If you have any questions, please feel free to reach out to me at carina.teixeira@kcl.ac.uk.