Module:
Mental health in the community

Week 4
Psychosocial approaches to care in the community

Topic 3
Community care in practice – Part 2 of 2

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Lecture transcript

Slide 3
One of the core issues for services is to ensure that the issues people face - their problems, needs, however you like to characterise it - are assessed.

So why is assessment important? Well, firstly, simply as an assessment tool: 'What are the problems I experience?' But it's also important as a bureaucratic means to identify entitlement to services. Remember the value, potentially, of a diagnostic label, so you get services specifically tailored to your needs-- somebody living with autism, for example.

Assessments can also be an agenda for action, moving from unmet to met need, and potentially and hopefully, in the longer term to no need at all. Finally, assessments can be important in terms of providing measures of outcome. Have services actually helped?

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One of the very important current concepts is recovery, and this comes with multiple meanings. So when my car breaks down, recovery service comes to collect it. If I've lost my files on my computer, I'll be extremely distressed, possibly violent, and may turn to a specialist provider of data recovery for my laptop. If I collapse in the street, hopefully somebody will put me in the recovery position. Finally, and perhaps most relevantly for the current recovery paradigm, recovery is implicit in programmes such as the 12 step programme, to be in recovery from addiction.

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'Recovery' in mental health terms seeks to offer a new perspective on living with mental health problems, which starts from the experience of the person with the identified problem. This perspective offers interesting insights into need and suggests changes in the way that services are organised. There is a huge literature on recovery. In my view, the best current text, published by Mike Slade in 2009, under the title, Personal Recovery and Mental Illness, which incidentally comes in a series on values-based medicine

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So the recovery model, sometimes called 'approach', 'movement', 'paradigm' - different terms could be used - is extremely fashionable amongst policymakers - so that I've policy documents from New Zealand, Canada, Australia, the New York State Department of Mental Health, and from the English Department of Health - all stressing that mental health policy emphasises the importance of recovery-- not necessarily defining what it means, I have to say.

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Now, Glenn Roberts and Jed Boardman in 2013 produced a useful paper, which looked at different ways of understanding recovery, and they describe one word which has three meanings and five usages. That's incidentally, a gross underestimate. So 'recovery' is commonly regarded as a natural healing response and an approximation to cure. So, most people get better from most things, most of the time. Clearly, recovery means recovery from symptoms and difficulties in response to effective care and treatment, as described in evidence-based guidelines - for example the National Institute for Health and Care Excellence guidelines.

Well, that's the sort of thing that as a doctor I'm interested in offering. I have to say as a patient, I'm interested in experiencing personal recovery, which they tell us is recovery the valued pattern of life and living, with or without ongoing symptoms and difficulties linked to an active personal commitment to working on recovery. So it's something you work on yourself, or that perhaps you can get help on the way from others.

Then there are recovery-oriented approaches and services. So that's about the overall pattern of care, support, and professional practice, which Roberts and Boardman say is based on learning what works from people in recovery. It's conducted by staff with appropriate qualities and skills in recovery supportive relationships.

Finally, they describe the recovery movement - a values-led collaborative endeavour of people in recovery, practitioners, and many others who they tell us are working to develop and transform mental health care and treatment. This recognises, they say, the concurrent value of diverse expertise developed through personal experience, research training, and the benefit of working together in partnership to co-construct and co-produce learning teaching and change. You'll note there a number of buzz words - code production, for example, being seminal in the recovery movement.

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What does all that mean? Well, clinical recovery I think means, fairly obviously, getting better. Personal recovery perhaps can be described as living well. Recovery-oriented approaches are perhaps ways to make services work in that recovery oriented way that Roberts and Boardman and many, many others espouse. In terms of the recovery movement, I think you probably know if you're in it, and you can certainly characterise if you're not in it.

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There are many striking definitions of recovery, and one that's of interest to me is Pat Deegan, who says, 'The goal of recovery is not to become normal. The goal is to deeply embrace the vocation of becoming more deeply, more fully human.' As our American definition tells us, recovery is 'a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment.' A group of psychiatrists from South London and Maudsley Trust stated, 'Recovery involves living as well as possible.' So many, many ways of looking at recovery. Royal College of Psychiatrists' influential definition, 'For many people, recovery is the process of developing a new sense of self, purpose in life, and hope. It is a journey for the individual and those is close to them rebuilding a satisfying life. Central to the theme of recovery is resilience, which allows for individual strengths and coping skills to surface, in spite of adversity.' And I think implicitly, that definition takes a lot from the work of Larry Davidson.

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So what does recovery add to our understanding of mental health care? Firstly, it acknowledges that the identified patient is an agent, rather than an 'illness'. It focuses on the person's goals and how to support achieving them. It emphasises the importance of hope and empowerment. It stresses the value of peer support and peer-led services. Recovery narratives tell us something about what makes a difference for individuals living with mental illness, and here, creativity is often emphasised as an important factor.

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Now, my background has been in psychiatric rehabilitation, and recently, we published a textbook on psychiatric rehabilitation. It's a longish book, nearly 500 pages, 31 chapters. In that textbook, we use a definition of recovery produced by Helen Killaspy and others. She defines rehabilitation as 'a whole systems approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and leads to successful community living through appropriate support.' So what are the components of a competent, community-oriented mental health service?

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Thornicroft and Tansella tell us that what's achievable in a high-resource setting isn't necessarily appropriate for a low-resource setting. For them, the bedrock of mental health services lies in primary care and all the epidemiological data tells us that. They also tell us that there's always going to be a need for some in-patient provision, and they describe their model as the 'balanced care' model.

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So low-resource settings, that will include primary, care with some limited specialist mental health staff and care. Medium resource settings - primary care with a stripped down general adult mental health service. And then in high resource settings - primary mental health, with general adult mental health services and additionally, a range of specialised adult mental health services, providing more detailed specialist care for particular kinds of problems.

Now, arguably this is in fact a bit blinkered. So in low and middle income countries, third sector organisations providing work, housing opportunities, and family support are very important and certainly flourish greatly.

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Operationalising all this-- and again, I'm thinking here largely of settings where resources are readily available, Thornicroft and his colleagues have come up with a set of service components, and you'll see these in almost all books about community mental health care: so services specifically dealing with crisis and emergencies; services offering early intervention (particularly for people with psychosis); services offering in case management and assertive looking treatment, so supporting people out of hospital; outpatient clinics; in many areas, day hospitals and partial hospitalisation programmes remain an important component of provision, although that's become much less fashionable, for example, in England; services that provide work rehabilitation, a particularly dominant model there being individual placement in support; in a textbook on community mental health, it's perhaps a surprise to have a chapter on inpatient treatment, which I happened to write; they also describe the necessity of residential care provision; and programmes to support family members and caregivers; they emphasise the importance of medication; managing recurring physical disorders; and programmes that help people manage their illness themselves. All these together form a comprehensive community mental health service. Remember inpatient treatment being an element of that.

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And as I said, this list of components is very similar to the content of any standard textbook on community mental health services or rehabilitation psychiatry, although it does emit a couple of recent trends. So for example, we now expect substantial contributions on peer support services and peer-led services, and movements such as the 'recovery college' movement. Each of these components is worthy of a seminar to provide a detailed description of the evidence base, but we don't have time for that. There's also something else missing, I think.

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For me, something that makes a really good community mental health service is a defined catchment area that the staff know well, and a community mental health service that has close relationships with primary care social services, housing authorities, education providers, faith

communities, which will incidentally all be quite specific both to that local area and the particular country one's working in.

Now, these community mental health services need a modicum of technical therapeutic skills relevant to the local need. So for example, for many years I worked in Londo - in Croydon - where we had very high numbers of asylum seekers, and so we had to develop the capacity to provide trauma focused work for those individuals, and clearly-- it's already emphasised-- good quality community mental health services require access to inpatient services and specialist mental health services for specific complex issues beyond the generic level of competence.

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Now, other elements are staff who care about their work, who are well-motivated and managed well locally. There's a need to focus on the needs of the person and their carers that goes beyond protocol-based treatments of defined disorders or conditions. But on the other hand, there's a need for an awareness of the functional impairments patterns associated with mental health problems and how these may be overcome. And above all, staff need to have an optimistic problem-solving approach.