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Chapter 3

A wellness approach to mental health recovery

Margaret Swarbrick

Introduction

Recovery is a deeply personal, unique process of regaining physical, spiritual, mental, and emotional balance when one has experienced illness, crisis, or trauma. Through this process, we manage associated challenges while adjusting attitudes, beliefs, and often life roles and goals. Thus recovery is a process of healing and restoring a sense of physical, mental, and spiritual balance (mind–body–spirit) during episodes of stress and crisis. Recovery is impeded by a life of poverty, poor access to high-quality healthcare and other needed health and social supports, and the effects of stigma, discrimination, and social exclusion. Mental health recovery is now being viewed in the context of wellness, initially introduced within public health. This chapter will explore mental health recovery in the context of a wellness model, recognizing that, philosophically, wellness—and health—can be viewed as the opposite of illness (as is often the perspective in biomedicine) or as part of a different dimension to that of illness (as is the perspective here) (Rudnick, 2002). Determinants of health will be reviewed and wellness strategies will be examined as a proactive means of promoting mental health recovery and social inclusion. A detailed philosophical discussion will not be attempted here, but the author's endorsement of wellness (and health) as separate from illness will philosophically inform this whole chapter.

Recovery and wellness

Around the world, "recovery" has become a vision, outcome, and framework for transforming lives and the mental health service delivery system. Strong advocacy by the service user survivor movement, as well as research and strong leadership by prominent leaders, promoted the notion of recovery (Deegan, 1988), now endorsed at an international level (Slade et al, 2008). Service users want the same things that most people in society desire, namely a sense of belonging, an adequate income, and a decent place to live. They aspire to fulfill various life roles and contribute to their community at large. Despite these generic similarities in overall goals, recovery remains a personal, unique process of (re)gaining physical, spiritual, mental/emotional, and intellectual balance after one has encountered illness, crisis, or trauma, (or often a combination of all three). For some, recovery means the ability to work, to live in housing of their own choice, to have friends and intimate relationships, and to become

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contributing members of their community. Recovery can be described as a process of healing and restoring *health and wellness* during episodes of illness, life stress, and resolution of traumatic experiences (Swarbrick, 1997).

In addition to embracing a recovery vision, community mental health practice is now shifting to adopt a focus on wellness. Wellness is defined as a conscious, deliberate process that requires a person to become aware of and make choices for a more satisfying lifestyle (Swarbrick, 2006). A *wellness lifestyle* includes a balance of health habits, including adequate sleep, rest, and good nutrition, productivity and exercise, participation in meaningful activity, and connections with supportive relationships (Swarbrick, 1997). Wellness views a person holistically (i.e. it involves more than just mental and emotional well-being), and includes physical, intellectual, social, environmental, occupational, intellectual, financial, and spiritual dimensions. The Wellness Recovery Action Plan (WRAP), which was introduced by Mary Ellen Copeland (Copeland, 1997), is a clear example of how service users have translated recovery and wellness principles into an effective self-care strategy that is now embraced widely within community mental health practice in the USA and throughout Europe and Asia. The wellness dimensions are defined and explained briefly in Box 3.1.

Box 3.1 Dimensions of wellness

Physical dimension: involves the maintenance of a healthy body, good physical health habits, adequate nutrition and exercise, and obtaining appropriate healthcare. It is important to empower people to focus on nutrition, exercise, smoking cessation, and stress awareness and reduction as means of self-care and prevention of co-occurring medical conditions. It is also important to offer services and supports that empower service users to establish healthy habits and routines and to access timely preventative and needed healthcare services.

Intellectual dimension: involves lifelong learning, application of knowledge learned, and sharing knowledge. We need to recognize people's creative abilities and help individuals to find ways to expand their knowledge and skills while at the same time helping them to discover the potential for sharing these gifts with others. Services and supports should help people to pursue personal interests and keep up to date on issues, as well as offering opportunities to share ideas.

Environmental dimension: involves being able to be and feel physically safe, in safe and clean surroundings, and able to access clean air, food, and water. This includes both our micro-environment (the places where we live, learn, work, etc.) and our macro-environment (our communities, country, and planet). Services and supports should help people to create living, learning, and working spaces that promote learning, contemplation, and relaxation.

Spiritual dimension: involves having meaning and purpose and a sense of balance and peace. This is one of two aspects of life that sustain many people during their recoveries. The mental health system sometimes views spirituality as pathology rather than as helping people to connect with cultural, religious, and/or spiritual traditions and environments that enhance self-identity.

Box 3.1 (Cont'd)

Social dimension: involves having relationships with friends, family, and the community, and having an interest in and concern for the needs of others and humankind. Social support and connectedness is a key ingredient for supporting recovery.

Emotional dimension: involves the ability to express feelings, enjoy life, adjust to emotional challenges, and cope with stress and traumatic life experiences. Emotional stability helps an individual to recognize conflict as being potentially healthy, and enhances self-acceptance and contentment.

Financial dimension: involves the ability to have financial resources to meet practical needs, and a sense of control and knowledge of personal finances. Financial instability can result in emotional distress. Therefore attention to financial/economic self-sufficiency is a central focus of assessment and intervention.

Occupational dimension: involves participating in activities that provide meaning and purpose, including employment, voluntary work, and engagement in meaningful activity connected to social roles. Through their jobs, people find self-definition, structure their lives, develop a sense of self-efficacy, develop and maintain relationships, maintain incomes that support financial wellness, and more. Underemployment and unemployment undermine recovery. Therefore access to evidence-based supported employment services is essential for any funded service delivery system, and is key to transcending the poverty trap that is too often faced by service users.

In terms of mental health recovery, a person can regain mental and emotional balance—even if mental illness and related symptoms persist—by focusing on the various aspects of overall wellness, including social support, spiritual connections, and taking care of their physical health by obtaining adequate relaxation, sleep, and nutrition. The need to attend to wellness is evidenced by the increased morbidity and mortality experienced by people with a serious mental illness, which is largely due to treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care (Parks et al, 2006), and is compounded by the adverse effects on health of medications prescribed for their psychiatric conditions.

Around the world, there has been a focus on mobilizing action to address this health crisis. Many service users have assumed key roles in helping the US Substance Abuse and Mental Health Services Administration (SAMHSA) to launch the Wellness Campaign (Manderscheid and del Vecchio, 2008). They are mobilizing efforts to address the considerably shortened life expectancy and reduced quality of life associated with living with a serious mental illness. The wellness campaign aims to motivate action to incorporate wellness as a means of enhancing quality of life, and demonstrate the value of focusing on improving health behaviors by incorporating the eight dimensions of wellness into recovery This reflects the critical need to embrace and implement a focus on wellness, and to advocate for health promotion models for community mental health practice.

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Being regularly engaged in meaningful and purposeful activity (occupational or vocational) is a key aspect of recovery from many health conditions, and has long been recognized as a central goal of rehabilitation services. The issue of whether service users should avoid stressful employment in the primary labor market has long been debated. Although modern thinking advocates helping people to choose their own level of employment, including full-time primary labor market work, large segments of the mental healthcare community do not fully embrace this, and unemployment rates for service users can be as high as 85%. Many of the service users who are working are underemployed, or are employed in positions that pay less than 150% of the prevailing minimum wage (Cook, 2006).

Almost everybody relies on a personal social network for both social and functional reasons. Our basic social needs are met by our relationships with friends and family, and include friendship, companionship, love, and belonging, We also rely on the people to whom we are close to discuss issues, to vent our feelings without experiencing judgment, to help us in countless practical ways, and to serve as an introduction and entrée so that we can expand our networks. Strong social networks and social support play a role in reducing the likelihood of disability, and in helping people to cope with aging and disability more successfully (Gottlieb, 1985).

Many factors contribute to this pattern of reduced social networks, including illness symptoms, family, ghettoization, and isolation during institutional treatment. Various attempts to help people with reduced community integration came together in the mid-1970s in the form of an intervention known as *social skills training* (Hersen and Bellack, 1976). This kind of intervention later became an integral part of *illness management and recovery (IMR) education* (Mueser et al, 2002). More recently, the importance of having five or more supporters is emphasized in the widely employed recovery self-management program known as *wellness recovery action planning* (Cook et al, 2011). Finally, while the gap is being both studied and closed, many service users may have less access to Internet-based social networking (notably Facebook) than the general population; this is an area that the service and self-help system have to continue to work together to remedy.

People in our social networks, including family members, can be thought of as our "natural" supports. "Natural supports usually involve relationships with family members, friends, co-workers, neighbors and acquaintances, and are of a reciprocal (give-and-take) nature. Such supports help one to develop a sense of social belonging, dignity, and self-esteem." This is in contrast to formal supports, which "usually involve some form of payment for services and may include relationships with service providers—such as counselors, therapists, line staff and care managers" (Temple University Collaborative on Community Integration, undated). Several factors contribute to the tendency for service users to have reduced family connectedness, including the psychiatric issues of the individual, family psychiatric histories, and societal stigma. Issues of parenting while pursuing psychiatric recovery are a complex multisystem challenge. Some mental health providers shy away from building and encouraging family connectedness. Psychiatric hospitals and hospital units are often found in isolated locations, have limited visiting hours, and/or have limited telephone access.

In order to implement a wellness framework it is important to look at issues of quality of life and social determinants. Quality of life is defined as general well-being of individuals and societies, and refers to a person's subjective well-being. Quality of life includes mental and physical health, financial security, relationships with others, community and civic activity, personal development and fulfillment, and recreation (Flanagan, 1976). Quality of life is very much related to the Social Determinants of Health framework, which recognizes that the economic and social conditions in which people live help to determine their health. Some conditions are a result of social, economic, and political forces, and include income and social status, social support networks, education and literacy, employment, social and physical environments, personal health practices and coping skills, access to health services, gender, and culture (Wilkinson and Marmot, 2003). These determinants can have a strong impact on health, healing, and quality of life, and are significant barriers to mental health recovery and wellness.

Why social determinants matter

Wellness is so very important because it provides a context for recognizing and addressing the social determinants of health that can facilitate or hinder recovery. A social gradient in health runs through society, with those who are poorest generally suffering the worst health. Many major diseases are determined by a network of interacting exposures that increase or decrease the risk of developing the disease. Individuals living with various forms of disability are often at greater risk of being negatively affected due to under- and unemployment, social isolation, access problems, and the negative impact of trauma and early adverse events (Wilkinson and Marmot, 2003).

It is clear that mental health recovery is affected by social determinants, and it seems very important to view people served by the mental health service delivery system through this lens. People who are living in poverty often have strained or limited social networks. In addition, people who are pursuing mental health recovery paths are too often subject to treatment that has harmful side-effects. We are finding that psychiatric medications often have an impact on other conditions and create disability resulting from long-term harmful metabolic and other side-effects to a greater extent than the disorders that they are intended to help to relieve.

Many service users become trapped inside a box—they become or believe that they are dependent on the medications they use, many of which are expensive, and therefore they do not want to risk losing public benefits by becoming employed, so they avoid employment and live on subsistence-level incomes, while the medical effects of the medications increase their need for medical treatment. Many people move into a culture of "entitlement," rather than seeking support to move beyond their illnesses and disabilities (occupational and intellectual imbalances). At the same time, many mental health providers demonstrate a strong pro-medication stance, and this is often reinforced by the advocacy of pharmaceutical manufacturers and some self-help organizations which embrace the "medical model." Under these circumstances, people often feel condemned to poverty, which then often undermines their confidence and

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Access to healthcare can also be limited by factors that are more strongly associated with mental health problems, including fear of stigmatization, a history of trauma, difficulties navigating the healthcare system, and cognitive problems. Stigma, including the real or perceived experience of being judged negatively or blamed due to having a mental health condition, is a significant factor that causes service users to feel discomfort in healthcare settings, and sometimes to reduce their use of needed healthcare. Anecdotal evidence on this point is strong. Many service users report that even when they are not manifesting psychiatric symptoms, physicians and dentists speak over them to their companions or caregivers. Others share anecdotes such as presenting to an emergency department with a leg fracture, and sensing a major change in triage nurse attitudes towards them after they have revealed that they are taking psychotropic medications.

Histories of physical, emotional, and/or sexual trauma are typically very common among service users. People who have histories of trauma avoid retraumatization in a variety of ways. Needless to say, routine healthcare involves a wide variety of intrusive dialogues, invasive procedures, and even intimate invasions. People who have received physical health interventions against their will, and/or been physically restrained in what was ostensibly a healthcare setting (both of these scenarios are common among people with psychiatric disabilities) are more likely to fear (and avoid) medical retraumatization.

Many service users are outside of inpatient settings but remain in community-based institutions such as boarding homes, adult homes, residential healthcare facilities, intermediate care facilities, assisted living, or nursing homes. The healthcare systems that fund and manage these facilities are complex, fragmented, and arcane, rather than being person centered. Many service users have considerable difficulty navigating and coordinating healthcare services. As a result, "care is less timely, safe, effective, and efficient" (Sofaer, 2009). These challenges are, of course, magnified for a person whose illness creates cognitive deficits, which may interact with low levels of health literacy. For people with notable cognitive and similar problems, as well as some degree of medical need, integrated and co-located models of care are strongly recommended (Bazelon Center for Mental Health Law, 2004).

However, there is increasing evidence that disparities in healthcare provision contribute to poor physical health outcomes, including a combination of systemic issues (such as the separation of mental health services from other medical services), healthcare provider issues (including the pervasive stigma associated with mental illness), and the consequences of mental illness and side-effects of its treatment.

Certain social determinants can be credibly addressed through services that integrate mental and physical healthcare and focus on recovery and wellness. Integrated care can help to address such social determinants as access to health services, gender and culture issues, personal health practices and coping skills, income, social status, and employment, social support networks and natural supports, education and literacy, and social and physical environments.

Factors associated with poverty in general involve the inability to pay for good-quality healthcare. Reliance on public clinics may not provide sufficient access to specialists or the continuity of a "medical home." Lack of financial resources also creates difficulties with transportation to obtain needed healthcare, especially in rural areas, and the inability to pay for and procure medically recommended items. With regard to the latter, people with very limited incomes tend to have difficulty purchasing recommended over-the-counter medications, vitamin supplements, and non-prescription appliances.

Cultural disparities with regard to healthcare use have been the subject of many reports in the healthcare community (see, for example, Harris, 2010). Some cultures have an inherent distrust of "western medicine," and myriad interventions have been developed to provide culturally competent outreach and care. There is also a clear gender disparity, with women typically making much greater use of general preventive care, and men being more likely to delay seeking care until a health condition becomes significant. A variety of factors can be cited to explain this disparity, including women's use of prenatal care and the fact that they are often responsible for managing the medical care of their children, and men's cultural conditioning to avoid signs of weakness. These disparities need to be considered when designing interventions to help service users to access and, more importantly, to return to physical and mental healthcare services, including peer support/self-help.

Health literacy is a necessary skill for understanding health conditions, communicating with health providers, management or prevention of illness, use of health treatment, ensuring safety during health treatment (e.g. understanding medication dosing instructions), and doing all of these things for the people and creatures whom we care for (e.g. our children and pets). Because mental health service users often encounter significant medical comorbidities and health conditions resulting from iatrogenesis, an adequate level of health literacy is vital. Most of the interventions that have been developed to improve the health of service users have focused on surveillance, treatment, access, and prevention or management of comorbid health conditions, rather than on helping people to improve their health literacy and their sense of healthcare autonomy. This is a trend that will require careful design and is therefore key for social inclusion, recovery and positive wellness outcomes.

A person's health behaviors can play a significant role in their overall long-term wellness. When dealing with psychiatric distress, people sometimes turn to behaviors such as heavy use of alcohol, tobacco, and other drugs, excessive or unusual eating, and self-injury. Each of these has negative health consequences. Relatively common approaches to maximizing physical health, such as ensuring adequate sleep, regular exercise, and a balanced diet with regular meals, and avoiding alcohol and other drugs of abuse, are all common ways to minimize the frustrations and impacts of mental health disorders. Although they do not have such a direct impact on mental health, regular bathing, avoidance of tobacco, regular hand washing, oral care, use of primary and surveillance medical services, physical health safety, and appropriate use of medications and supplements are all predictors of health and longevity, and can often be negatively influenced by psychiatric symptoms, which suggests that there is a need for extra attention to these areas. Emerging services are showing some promise in

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Conclusion

The recovery paradigm has made some significant strides towards changing where services are offered, what practice models are used, and what outcomes are measured. The notion of wellness and social determinants of health offers an expanded framework for redesigning, delivering, and implementing holistic person-centered services that foster empowerment and self-determination. This chapter has offered an overview of a wellness model as well as the relevance of the social determinant framework, along with some suggestions for personal and system-level change towards areas and methods for intervention. Comprehensive program, system, individual service user, and provider level involvement will be crucial for community mental healthcare to design, deliver, and evaluate services that take into account the social determinants of health, focus on wellness, and achieve significant positive health outcomes.

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