RECOVERY
IN PROGRESS

FUTURE RECOVERY-BASED SERVICES
DESCRIPTIONS, EXAMPLES AND EVIDENCE

MARY O'HAGAN
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INTRODUCTION

This paper is a vision for a recovery based service system, with some best practice examples and evidence which I developed through my work with:

- New Zealand Mental Health Commission (2005-07)
- New Zealand Mental Health Advocacy Coalition (2007-08)
- a number of national stakeholder meetings (2006)
- a literature review on the evidence base for recovery responses (2006)
- an internet search (2008)

It has been adapted to fit English conditions.

This is a work in progress – a living document. Some examples, evidence and references for the evidence have yet to be included. 'Recovery in Progress' will be regularly updated. Recipients will receive all the updates.

CONTENTS

1. FUNDAMENTAL BELIEFS

What are the fundamental beliefs that drive all the service and societal responses to madness? These beliefs can be so fundamental we are not really aware of them. To create deep change in services we need to change some of these fundamental beliefs.

Perhaps the most basic belief that needs to change is the view that madness has no value or meaning. This belief generates fear, pity, discrimination, exclusion and the coercion of people with major mental distress. Madness is often a gruelling experience that involves states of terror, confusion and despair. But the pain associated with it does not have to render it valueless. Experiences like grief, dying in pain for a just cause, the path to spiritual enlightenment or being falsely accused can be just as gruelling. The difference between these states and madness is that society legitimises them more, and allows for the possibility of growth, recovery or justice. Fortunately the recovery philosophy gives the madness experience legitimacy by valuing subjectivity and recognising the whole context of people's lives. It also provides a pathway through it.

Some of the assumptions that arise out of the devaluing of madness are that the people experiencing it lack competence and are prone to violence. This has led to a somewhat naive and simplistic community consensus around personal safety and mental health, which needs to be debated in the public arena. It assumes that mad people are not responsible for their unpredictable or violent behaviour; therefore someone else needs to take control. For the last two hundred years or more, communities have abdicated their responsibility for people with serious mental distress to mental health experts and services. These experts and services are expected to take total responsibility for people with mental distress, particularly those in crisis, who should be contained and tightly controlled. Therefore, when something goes wrong, mental health services are fully to blame for not containing and controlling the person.

There are some implicit assumptions in this consensus that are unsustainable. Firstly, that people with mental distress are not capable of taking any responsibility for their actions; in many cases people, even when in crisis, have capacity for personal responsibility. Secondly, that mental health services can avert every disaster; clearly human beings, no matter how skilled, are fallible in their predictions. The third assumption is that coercive practices are required to keep the community safe from violent, unpredictable people. The truth is only a small percentage of people with mental distress fit this category, just as a slightly smaller percentage of people without mental distress do.

Unfortunately, this unrealistically demanding consensus has led to risk-averse practices in mental health, such as compulsory treatment, locked doors and other restrictions on liberty. Sometimes these responses are driven more by possible risk to the reputation of the organisation or professionals than to what is optimal for the person experiencing mental distress. In addition to this, mental health practitioners and spokespeople in the public arena, who are understandably on the defensive, tend to publicly collude with this consensus instead of questioning it.

Organisations in the public and private sectors have a range of stakeholder expectations to meet. Private companies often just have to respond to their customers and shareholders; normally if they please the customers this will increase profits which will please the shareholders. This seamless alignment of interests does not happen in publicly funded health and social services because of their complex ownership, accountabilities, funding arrangements and a wide range of stakeholders who may have conflicting views. In public services, particularly mental health, regard for the customer does not reach the private sector standard

that 'the customer is always right'. Often private enterprises transform themselves through a single-minded customer focus, but it is difficult for public service agencies with a politically charged role of control and containment, to achieve this.

Without the unambiguous incentive to transform responses for the people who use them, services and systems risk becoming complacent and even self-serving. This is often characterised by lack of vision and protection of the status quo. Power struggles may develop causing people to retreat to their own silos. Communication slows to a trickle and information may be even consciously withheld. Resources are wasted and very poor service delivery is tolerated. The expression of conflicting views may be discouraged and external scrutiny met with denial or defensiveness. Transformation cannot happen in these dysfunctional organisations.

In addition to this, some argue that the rising dominance of services in the lives of marginalised people in contemporary society has to an extent disabled communities and individuals and made them over-dependent on services. Though professionals and services can be of huge benefit, their tendency to focus on deficits and not strengths can prolong or even manufacture problems. Contemporary health and social services are powerful economic and social entities, where the drive to survive and grow can happen at the expense of the people they are supposed to serve. Inside these services professional and management experts have traditionally controlled access, language, knowledge, culture and the kinds of services provided. Their authority has overridden that of stakeholders such as service users, families and marginalised communities.

These kinds of beliefs and cultures need to change if we are to ever achieve a truly recovery-based service system.

2. PURPOSE AND VALUES OF SERVICES

2.1 PURPOSE – RECOVERY

The purpose of services and other responses is to support people and their families to lead their own recoveries – to increase well-being and to reduce mental distress. For people with mental distress this includes the recovery of their personal power and valued place in family and society. For people with loss of well-being it means the recovery of optimal well-being. For families it means the recovery of their collective well-being. For communities and services it includes the anticipation of recovery, and the wholehearted support of it.

2.2 MADNESS – A FULLY HUMAN EXPERIENCE

People recognise the importance of social, economic, political, psychological, spiritual as well as biological contributors to mental distress and to loss of well-being. Mental distress is seen primarily as a way of being, with associated personal and social barriers to living well, as well as a full human experience that value and meaning can be derived from. It is not usually referred to as illness.

2.3 SELF-DETERMINATION – THE PRIMARY VALUE

People working for the benefit of people with mental distress believe in their self-determination. They foster the leadership of service users as individuals in their own recovery and at a collective level through their advocacy and workforce roles.

3. PEOPLE INVOLVED IN SERVICES

The new purpose and values of services change the way people feel, think and behave. Everyone is encouraged to be informed, active and competent in their role – not just the paid workforce, but people who use services, their families and the wider community.

3.1 PEOPLE WITH MENTAL DISTRESS

People with mental distress don't struggle much with internalised stigma, gloomy predictions and loss of hope. They are supported to take responsibility for their own lives, negotiate the services they want, and make their own informed decisions about their lives. As a collective, people with experience of mental distress are a major force, demonstrating leadership in advocacy and in the workforce at all levels.

3.2 FAMILIES

Families retain hope for their family member. They don't feel blamed. They are supported and educated to enhance the recovery of their family member as well as the recovery of the family unit, from the stresses associated with mental distress. All families have access to family peer support and recovery education. Mental health workers welcome their involvement knowing that they can be part of the solution.

3.3 THE WORKFORCE

People working in services feel valued by service users and their families for listening, their compassion and for doing whatever it takes. Staff are well supported by management and they have access to information on their performance that assists them to improve. In a more benign political and community context, they are under less pressure to manage risks to the organisation and their professional reputation; they are freer to take reasonable risks and manage it in partnership with the service user and their family.

The wisdom gained from experience of mental distress is highly valued and seen as a qualification for working with people with mental distress. Groups such as Black and minority ethnic people and families also have a much larger presence in the workforce. No one in the workforce fears discrimination if they openly identify their own experience of mental distress.

3.4 COMMUNITIES AND POLITICIANS

People in the wider community understand that people with mental distress are not especially prone to violence, usually retain their competence and that services cannot stop all tragedies. They see major mental distress as a fully human experience and think discrimination against people with mental distress is wrong. Community members, without the blinkers of fear and discrimination, are valuable stakeholders in the planning, delivery and evaluation of responses.

Politicians have a sense of urgency about the huge personal, health, social and economic costs of high social inequality and trauma. Governments develop new policies, funding approaches and incentives to coordinate work across the spectrum to reduce social inequality and trauma in the population.

4. KEY ELEMENTS OF SERVICES

4.1 NEW LANGUAGE

The old language in mental health settings valued the objective over the subjective and external authority over internal autonomy. The new language values both subjectivity and objectivity, and emphasises internal autonomy over external authority. Some of the old hospital language mimics military and criminal justice language. People are detained, they go AWOL (absent without leave), they are discharged. It no longer makes sense to use this kind of language. In the context of a mutually informed and respectful dialogues between mental health workers and service users, the workers feels uncomfortable describing service users with terms like 'non-compliant', 'lacking insight' and 'inappropriate'.

4.2 EASY ACCESS

Individuals and families know where to find independent information on the availability and quality of services. Services provide the easiest access they possibly can. This is a priority. People are not denied access to help on the basis that their distress or lack of well-being are not severe enough. People working in services with service navigation skills, either provide for people who come to the service or stay in contact with them until they find help for them elsewhere. People in prison and forensic services have access to the same range and quality of mental health responses as other citizens.

4.3 VOLUNTARY USE OF SERVICES

Compulsory treatment is used rarely and briefly. There is no seclusion or compulsory ECT. People working in mental health services strive to prevent compulsory interventions. Any use of compulsory powers is done humanely and treated as a critical incident. This is matched by a changed emphasis on professional responsibility; providing the best possible advice and assistance is in the foreground, while containing clinical risk does not dominate.

Evidence and examples

Vermont's vision of a public system for developmental and mental health services without coercion
http://www.angelfire.com/vt/WCYAC1/rod.pdf

Force in Mental Health services: International User/Survivor Perspectives
http://www.nq-anzcmhn.org/papers/Force%20in%20Mental%20Health%20Services.PDF

Position on Out-patient Commitment
http://www.bazelon.org/issues/commitment/positionstatement.htm

Commitment law won't help the mentally ill
http://akmhcweb.org/ncarticles/SuddersEditorial6-02.htm

Personal wellness action plans and advance directives, New Zealand
http://203.86.194.7/Gems/healthaction/WellnessPlanning.pdf

Advance directives update, England
http://www.mhf.org.uk/publications/?entryid=39418&EntryId5=43108

Advance directives in mental health care and treatment, New Zealand
http://www.mhc.govt.nz/documents/0000/0000/0083/MENTALHEALTH_HDC_BROCH.PDF

4.4 NATURAL LOCATIONS

Virtually all responses are delivered in an ordinary community location, such as a primary care setting, at community centres, shopping malls, schools, workplaces, a person's home or online. Residential rehabilitation takes place in shared community housing. Residential crisis or acute services are small and homelike. There are very few hospital based services. The community residential services do not have the institutional trappings of closed circuit television and other heavy security features but rely more on the presence of staff and their negotiation skills to keep people safe. Environments are emotionally safe as well as physically safe.

Evidence

Qualitative research shows that the majority of service users prefer alternatives to hospital as places of support. Community based crisis houses and home-based treatment produce equal or better clinical results to inpatient treatment and also improve service user and family satisfaction.

The Acute Crisis
http://www.mhc.govt.nz/documents/0000/0000/0126/THE_ACUTE_CRISIS.PDF

4.5 TRAUMA INFORMED RESPONSES

There is widespread recognition of the role of trauma in the lives of people with loss of well-being and mental distress. This has led to the creation of trauma-informed service systems that are safe and nurturing for service users and prevent the re-traumatisation that comes from violence and coercion. These services place high value on service user leadership, recovery, and strengths based approaches. Trauma informed services are regarded as necessary for all services users whether they have a trauma history or not. Trauma informed services do universal screening for trauma as soon as practicable after people come into the service, and provide specific responses for them.

Evidence and examples

The National Center for Trauma-Informed Care
http://mentalhealth.samhsa.gov/nctic/

Disturbing the Sounds of Silence
http://www.mhc.govt.nz/publications/documents/show/93-occasional-paper-number-6-disturbing-the-sounds-of-silence-mental-health-services-responsiveness-to-people-with-trauma-histories-september-2004-word-224kb

4.6 EQUALISING RELATIONSHIPS

People know that one of the most important predictors of a good outcome for people using mental health services is the quality of the relationships they have with mental health workers – even when they are primarily receiving drug therapies from them. Mental health workers strive to show people respect and treat them as full human beings who have strengths and abilities as well as problems. They promote their autonomy. They are practiced at asking people what they need, listening with empathy and compassion, and giving hope and encouragement.

Examples

Self directed care in England
http://in-control.org.uk/

Self directed care in USA
http://www.bazelon.org/issues/mentalhealth/publications/DriversSeat.pdf

Vermont's vision for services without coercion
http://www.angelfire.com/vt/WCYAC1/rod.pdf

4.7 RESPONDING TO DIVERSITY

The responses, and the workforces to deliver them, reflect our cultural diversity, ensuring that people of all cultures are well served.

Black and minority ethnic health inequalities are decreasing. They are developing their own services and workforce. These services are available to all black and minority ethnic groups where there is sufficient concentration in the local population. The responses they provide may include traditional healing methods, cultural practices and activities as well as a focus on families.

People with English as a second language have quick access to trained interpreters.

People with physical, sensory and intellectual disabilities have good access to services and information. All buildings are accessible and information is immediately available in a variety of formats.

People in rural communities have more equitable access to services through the use of communication technologies

4.8 BOTTOM-UP LEADERSHIP

Individuals, families, and communities most affected by services, have the capacity and structural power to govern and lead in the development of services. In particular people with mental distress are leaders and influencers within services.

The workforce sees a large part of its role as community development. They have the values and expertise to develop equalising relationships with stakeholders. They are able to work with people with mental distress, their families and affected communities to assess their capacities, develop their leadership, build empowering organisational structures and find the necessary resources for them to govern and lead in the design, delivery and evaluation of services.

Examples – Consumer advisory services

Consumer Advisors Overview, New Zealand
http://www.moh.govt.nz/moh.nsf/pagesmh/7211/$File/regional-cancer-network-forum-bvickers.pdf

Consumer Advisors, Auckland
http://www.mindandbody.co.nz/index.php?ti=26

Office of Consumer Affairs, Prince William County, Virginia
http://www.pwcgov.com/default.aspx?topic=010009000830000609

Office of Consumer Affairs, Nevada
http://www.hhs.state.ne.us/beh/mh/mhadvo.htm

Office of Consumer Affairs, Florida
http://www.dcf.state.fl.us/mentalhealth/mhtransform/ocfa.shtml

5. CORE RESPONSES TO INDIVIDUALS

Services provide a broad range of core responses that address the full variety of contributors to and consequences of mental distress and loss of well-being. These core responses are better seen as functions rather than roles; a few of these functions could be performed by the same person.

Addictions responses are integrated with the other responses for people with mental distress and loss of well-being. All mental health teams, whether in the primary or specialist mental health setting, have day to day access to addictions expertise and vice-versa.

Services provide of a broad range of core responses that address the full variety of contributors to and consequences of mental distress and loss of well-being, such as, trauma, social inequality, racism, biology, addictions, physical illness and social exclusion.

Addictions responses are integrated with the other responses for people with mental distress and loss of well-being. All mental health teams, whether in the primary or specialist mental health setting, have day to day access to staff with addictions expertise. There are some stand alone addiction services and these have easy access to mental health expertise due to the large overlap between addictions, mental distress and loss of well-being.

'Responses' is another word for all the funded interventions, opportunities or resources designed to benefit people with mental distress, loss of well-being and their families. These core responses are better seen as functions rather than roles; a few of these functions could be performed by the same person.

5.1 SERVICE NEGOTIATION

This is a process where the service user, the professional and often their families, jointly identify their problems, strengths and aspirations and negotiate how services could assist. This process uses the person's own expertise about their context and their subjectivity, as well as the practitioner's expertise and willingness to accommodate various viewpoints. It culminates in a recovery plan which is regularly reviewed.

5.1.1 Recovery Planning

There are a variety of methods in recovery planning. By definition recovery plans must be driven by service users and cover the whole of a person's life, not just treatment or mental health services.

Some recovery plans such as the Wellness Recovery Action Plans (WRAP) are a self-help tool. WRAP focuses on strategies to monitor and reduce distressing 'symptoms'. When this type of planning is initiated by services they are often called relapse prevention plans or crisis prevention plans. WRAP and other similar plans are not full recovery plans. Recovery plans focus on reaching your aspirations in life as well as preventing crises.

Examples

For more information on WRAP see:
http://www.mentalhealthrecovery.com

For an introduction to recovery planning see:
www.carecoordination.org/presentations/Recovery_Planning.ppt

5.2 SERVICE NAVIGATION

Service navigation ensures people with a number of needs have access to all the services, resources and opportunities they need in the primary, specialist mental health and social sectors, and in their communities. There is no standardised definition of this work. As a function service navigation is core to the care programme approach, case management, brokerage and service coordination. It is also a feature of self-directed care.

Evidence

The service navigation function works best when combined with a support function in the same worker or team.

Qualitative research shows that service users value a high level of personal contact and support, and goal planning.

Outcome studies show the most successful programmes for people with severe mental distress have members of the same team working with the client on a range of their needs such as benefit entitlements, money management, relationship problems, moving house and getting a job rather than referring to other specialist services.

There is consistent evidence that assistance and support to gain and maintain role such as employment , education and independent housing is more effective than training or skill-building to get people ready for these roles.

5.2.1 Direct payments and personal budgets

Direct payments, personal budgets and individual budgets are a key feature of self-directed care. Service users are allocated a budget to purchase the goods and services they require to assist recovery. This is a rights based approach that enables people to designing and control their support.

Examples

Department of Health guidelines on direct payments, England
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4131060

Some examples from the USA
http://www.self-determination.com/articles/Cost_and_quality_data.pdf

Evidence

The longer people are on individual budgets and work with self-directed support the better the outcomes. Other benefits include higher levels of independence and support commissioned from community facilities. **[Ref]**

5.3 DAY TO DAY SUPPORT

This is needed by some service users for tasks such as housekeeping, child minding, planning routines or facilitating social contact. It is available to people in times of crisis as well as those who need ongoing support of this kind. Currently, much of this work is done by support, time and recovery workers.

Evidence

Qualitative evidence shows that nature of assistance is varied and may include assistance with finance and bill paying assistance, transport, shopping, laundry, housework, leisure and social activities.

Qualitative research shows supportive interpersonal responses both in crisis and daily life are vital to recovery.

Research shows that emotional support i.e. having someone to talk or "be" with is highly valued by service users.

5.4 CRISIS SUPPORT

When people are in crisis they have empathic people with training in crisis support, to care for them, listen to them and attend to their spiritual, psychological and social needs. They have the support, values and skills to ensure their safety without habitually using forced treatment or inadvertently re-traumatising people when they are at their most vulnerable.

Examples

Report of eight community based crisis services, England
http://www.mentalhealth.org.uk/publications/?EntryId5=43125&p=3

Anam Cara, England
http://www.guardian.co.uk/society/2001/oct/24/guardiansocietysupplement9

Soteria House, California
http://www.moshersoteria.com/soteri.htm

Peer run crisis house, New Zealand
http://www.wellink.org.nz/services/keyweway.htm

Community clinical and peer staffed crisis house, New Zealand
http://www.wellink.org.nz/services/stars.htm

Evidence

The Acute Crisis
http://www.mhc.govt.nz/documents/0000/0000/0126/THE_ACUTE_CRISIS.PDF

5.5 EMPLOYMENT SUPPORT

Employers are equipped to create mentally healthy workplaces and negotiate reasonable work conditions for diverse needs and talents. People with mental distress are offered flexible support to get and keep employment.

Expert briefing on employment support, Department of Health, England
http://www.sesami.org.uk/employment_report.pdf

Examples

Review of supported employment programs, USA
http://www1.nmha.org/pbedu/adult/supported_employment.pdf

Employing service users in mental health services, SW London & St Georges NHS Trust
http://www.swlstg-tr.nhs.uk/work/user_employment_programme.asp

Rethink employment services, England
http://www.rethink.org/how_we_can_help/our_services/employment_and_train.html

Orygen youth employment services, Australia
http://www.orygen.org.au/docs/RESEARCH/Vocational.pdf

Reasonable accommodations in employment , USA
http://www.bu.edu/cpr/jobschool/

Evidence

Supported Employment is effective in assisting people with ongoing mental health problems, to achieve independent employment.

Earlier studies show that training in a sheltered environment does not lead to competitive employment.

Robert Drake on why supported employment works
http://www.scmh.org.uk/news/2008_use_proven_ways_of_getting_into_work.aspx

Editorial – Journal of vocational Rehabilitation 27:1 (2007)
http://iospress.metapress.com/content/048nx88577450267/fulltext.pdf

Articles – Journal of vocational Rehabilitation 27:1 (2007)
http://iospress.metapress.com/content/?k=%22journal+of+vocational+rehabilitation+27+(2007)%22

5.6 EDUCATION SUPPORT

Education support is available for people with mental distress at primary, secondary and tertiary levels and may involve liaison with staff and teachers, study skills, a teacher aid, extensions on assignments or extra tuition.

Examples

Supported education service, Boston University
http://www.bu.edu/disability/services/psychological.html

The Village, Los Angeles
http://www.village-isa.org/Services/supported_education.htm

Reasonable accommodations in education, USA
http://www.bu.edu/cpr/jobschool/

Evidence

Best practice in supported education, USA
http://www.socwel.ku.edu/projects/SEG/bestpracticesSE.html

Supported education – a review of the evidence, USA
http://www.psychosocial.com/IJPR_11/Supported_Ed_Strategies_Leonard.html

There is little evidence on educational support. Much more research is needed in this area.

5.7 HOUSING SUPPORT

There is very little staffed accommodation and most people are given support to find and keep their own homes.

Examples

Wellink, New Zealand
http://www.wellink.org.nz/services/homelink.htm

Housing program, Toronto
http://publish.uwo.ca/~cforchuk/cura/

Consumer run housing feasibility study, Ontario
http://www.mentalhealthrights.ca/EXECSUMMARY.pdf

Supported housing, New York
http://www.housingoptions.org/services.htm

Evidence

A variety of supported accommodation models are used around the world, with some evidence that people would rather live in their own homes with visiting support if necessary. This provides greater opportunities to maintain supportive social relationships.

5.8 PEER RUN SERVICES

Peer-run services delivered by others who have been through similar experiences, are available to all people with mental distress as well as to families. Peers only can deliver peer support services but they can also deliver services that don't have to be delivered by peers such as service navigation or housing support.

5.8.1 Peer support

Peer support is routinely offered to all service users and families when they first start using services. Peer support services can include:

- telephone support services
- peer mentoring
- web based Internet support
- self-help groups
- employment programmes
- drop in centres
- crisis care
- individual and systemic advocacy.

Examples

Types of peer support:
http://www.cdsdirectory.org/programs.html

Interlink Self-Help Center, California
http://www.interlinkselfhelpcenter.org/

Mind and Body Consultants, New Zealand
http://www.mindandbody.co.nz/media/peersupport.pdf

Freedom Center, Massachussetts
http://www.freedom-center.org/

Specialised Peer Support Program, Georgia
http://www.gacps.org/Home.html

Recovery Innovations (formerly Meta Services), Arizona
http://www.recoveryinnovations.org/

Intentional Peer Support, Shery Mead, USA
http://www.mentalhealthpeers.com/aboutshery.html

Family mental health recovery
http://www.familymentalhealthrecovery.org/

Evidence

Emerging evidence on peer support suggests it is associated with positive outcomes:

- increase of well-being
- reduction of symptoms and hospitalisation
- satisfaction with services
- increase in personal empowerment

Consumer control is the most important element of effectiveness other elements identified are; lack of coercion, belief systems and values that support the peer principle, free services , service user developed rules, formal peer support activities, and a sense of community.

Consumer operated Service Program (COSP) research results, USA
http://www.psych.uic.edu/uicnrtc/nrtc4.webcast1.jcampbell.transcript.pdf
http://www.psych.uic.edu/uicnrtc/nrtc4.webcast1.jcampbell.slides.pdf

Emerging research, USA
http://www.power2u.org/emerging_research_base.html

There is very little research in family to family support.

5.8.2 Recovery education

This uses a health promotion approach that gives people tools to manage their whole lives – from internalised stigma, to finding meaning in their experience, getting the best out of services, to finding friends, houses or jobs. Family recovery education gives families the tools to manage their own responses to their relative's mental distress as well as the tools to support their relative's recovery. Recovery education is led by service users who bring in experts as required. It can be done online, in a classroom setting or through a mentor. The focus of recovery education is personal development and the content includes:

- Finding meaning in experience and reframing people's stories to help recovery
- Recovery planning – staying well, relapse prevention, crisis planning
- Information on mental distress, treatments, services and rights
- Getting the best from mental health and other services
- Service user perspectives and the movement
- Understanding family perspectives
- Practical strategies for reducing self-stigma
- Dealing with stress

- Getting organised
- Building social supports
- Parenting and relationships
- Getting housing, work, education
- Food, exercise and fun

Examples

Recovery education programme, Boston University
http://www.bu.edu/cpr/services/health/index.html

Recovery education, Arizona
http://www.recoveryinnovations.org/riazrecoveryed.html

Online recovery education, USA
http://www.softconference.com/dbsa/default.asp

Recovery education for families, USA
http://www.nami.org/template.cfm?section=Family-to-Family

Recovery Education for families, Canada
http://www.familymentalhealthrecovery.org/courses/mental-health-recovery-series/

Evidence

There is good evidence for the effectiveness of psycho-education but recovery education is a newer approach, much wider in scope and is service user driven. There is limited evidence on recovery education.

5.9 TALKING THERAPIES

Talking therapies are available to all who need them and are subsidised or free of charge in the specialist or primary setting. Some talking therapies focus on techniques to alter thinking patterns, while others may explore the psychosocial context of distress. People affected by trauma have access to therapies that directly address the impact of their trauma and facilitate recovery from it. Black and minority ethnic groups have good access to therapists from their own cultures.

Examples

- Interpersonal psychological therapy (IPT)
- Cognitive behavioural therapy (CBT)
- Dialectic behavioural therapy (DBT)

Evidence

CBT is an effective treatment for mild to moderate depression and generalised anxiety and panic disorders and obsessive compulsive conditions.

CBT may be effective when used in conjunction with medication for people with people experiencing the psychosis spectrum.

Trauma informed group CBT programmes with stress management have been found to be effective for post traumatic stress disorders.

IPT has efficacy for depression, with some suggested increase in effectiveness when combined with antidepressants.

DBT has good outcomes in the treatment for people with borderline personality disorder diagnosis.

There is also evidence that service users with depression prefer psychotherapy to antidepressants.

5.10 DRUG THERAPY

Drug therapy is offered as one of a range of options rather than the backbone of treatment and support. People enter into drug therapy in collaboration with the prescriber, with good knowledge of beneficial and adverse effects and with confidence that any adverse effects will be well managed. The ultimate aim of taking psychiatric drugs is to enhance recovery, not to suppress symptoms. Service users are encouraged to experiment with drugs in collaboration with the prescriber so they get the maximum benefits and minimum adverse effects. Choosing not to take drugs is a valid option which the prescriber is willing to advise on.

Example

Shared decision making, Patricia Deegan, USA
http://psychservices.psychiatryonline.org/cgi/reprint/57/11/1636

5.11 COMPLEMENTARY THERAPIES

The state funds some complementary therapies, especially as an adjunct to other therapies; for example massage, acupuncture, meditation or natural supplements. Though many of these treatments lack a conventional evidence base many people who use them have found that they provide relief, tranquillity and meaning to their experience. The increased availability of complementary therapies is a response to the high value placed on them by people using services. Efficacy for the individual defines what is therapeutic.

Examples

Types of complementary therapies, England
http://www.mentalhealth.org.uk/information/mental-health-a-z/complementary-therapies/

Evidence

This is an area that lacks good research but despite this some evidence is clear.

- Complementary alternative responses have a high level of satisfaction when compared to traditional treatment. One survey identified 86% multiple complementary practices as beneficial to their mental health

- Exercise has been found to be effective in reducing symptoms of depression, both on its own and as an adjunct to existing treatment

- Light therapy is found to be effective for seasonal affective disorder

- St John's Wart may be effective for treating mild to moderate depression

- Music therapy alongside standard care for people with serious mental illness is proven to be of assistance.

5.12 INDIVIDUAL ADVOCACY

Advocacy is actively advancing or protecting the rights and interests of service users. It enables people locked into a power imbalance to achieve a more equal relationship. Individual advocacy is available to everyone using services to assist them make complaints that are quickly responded to and to ensure that the small number of people under compulsory treatment have reliable information and representation. Advocates, whether legal, peer or lay, act on their clients' instructions, showing a commitment to human rights. Advocacy can intercede in complaints or problems with mental health and other services, such as housing education or employment.

For more information on advocacy
http://www.mind.org.uk/Information/Booklets/Mind+guide+to/advocacy.htm

Examples

SE Pennsylvania Mental Health Association individual advocacy services
http://www.mhasp.org/advocacy/index.html

Minnesota Mental Health Association individual advocacy services
http://www.mentalhealthmn.org/

National Mental Health Advocacy Services, USA
http://www.narpa.org/

Evidence

Specialist advocacy working along service users can be very effective in increasing consumer satisfaction and reducing rates of rehospitalisation.

Peer–led advocacy can assist in a greater increase of well being for participants.

Service users emphasise a need for advocacy due to discriminatory practises of treating individuals with mental illness differently from others.

6. RESPONSES TO POPULATIONS

6.1 PREVENTION

The prevention of mental distress and loss of well-being are the responsibility of all sectors, not just health. Prevention addresses the social determinants of mental distress and loss of well-being, such as trauma, social inequality and racism.

6.2 PROMOTION

Well-being promotion targets at-risk populations such as people with mental distress, young people, Black and minority ethnic groups and socially disadvantaged people. Promotion activities dovetail services for individuals with mental distress or loss of well-being. Well-being promotion of Black and minority ethnic groups is led by them.

6.3 ANTI-DISCRIMINATION AND SOCIAL INCLUSION

More people with mental distress are visible and valued members of their communities. There is an ongoing anti-discrimination campaign that uses social marketing, media monitoring, policy development and local initiatives to advocate the full human status of mad people and zero tolerance of discrimination. The emphasis has shifted from awareness raising to behaviour change. The underlying message in all anti-discrimination work is the legitimisation of madness, and the rationale for action comes from human rights and recovery perspectives rather than a medical perspective.

The media regard discriminatory coverage on the basis of mental distress as unacceptable. The specialist and primary mental health workforce takes responsibility for ensuring they and other agencies have a clear focus on social inclusion and responding to internalised stigma.

As time has gone on the emphasis has shifted from awareness raising to behaviour change. The media regard discriminatory coverage on the basis of mental distress as unacceptable as discriminatory coverage on the basis of ethnicity or gender. The mental health workforce takes responsibility for ensuring they and other agencies have a clear focus on social inclusion and respond to internalised stigma.

Examples

Like Minds, New Zealand
http://www.likeminds.org.nz/

See Me, Scotland
http://www.seemescotland.org.uk/

Time to Change (formerly Moving People), England
http://www.movingpeople.org.uk/

Evidence

NIMHE review on what works, England
http://www.sesami.org.uk/stigmascoping_summary.pdf

Rethink on what works, England
http://www.rethink.org/document.rm?id=131

7. SECTORS

A broad range of responses requires a broad range of delivery and support agencies. The hub of service delivery could be an expanded primary health sector that works closely with a reduced specialist mental health sector, with social services, community resources, public health and human rights agencies.

7.1 COORDINATION AND INTEGRATION

All the involved sectors have developed many ways to cooperate or integrate and this is second nature to the workforce. Collaborative relationships are the norm across the different services, sectors and communities, as well as up and down the system from policy through to funding to delivery. Collaboration includes coordination and integration.

Integration in its most developed form refers to a single system of service planning, funding and/or delivery that is established and managed by agencies that remain legally independent.

Coordination refers to informal co-operative networks from different teams, agencies and sectors working together on a common goal in policy, funding, planning or delivery.

Integration and coordination are achieved, for example, through joint planning and pooled funding, through moving workforces between teams, services and sectors, through information sharing, or shared use of communications technologies for online or distance service provision.

7.2 PRIMARY MENTAL HEALTH

Primary services may be the most common point of access to services for people with mental distress and loss of wellbeing. They assist people to self-manage and provide access for people to use services in other sectors if needed.

Community mental health centres and many support services may have merged into primary health settings, where most therapeutic and support services for people with mild, moderate or severe distress are provided. Service negotiation, navigation, most prescribing and talking therapies, day to day support, peer support and recovery education, may be part of an expanded primary health focus for all people mental distress who need them, irrespective of whether their distress is severe or mild, long term or short term.

Mental health clinicians within the primary setting mainly deal with people with the more severe forms of mental distress but they are also available to advise their primary health colleagues and to facilitate referral to specialist mental health services.

People with major mental distress also have enhanced access to physical health promotion and services to counter their alarming mortality rates.

7.3 SPECIALIST MENTAL HEALTH AND SOCIAL SERVICES

Specialist niche mental health and social services include some, but not always all, acute services, forensic services, early intervention services, child and youth services, older people's services, addictions services and psychotherapeutic services. They offer crisis support as well as some therapies and supports to people with severe distress, though many of these people are also using support services from primary mental health and other sectors.

7.4 VOLUNTARY SECTOR SERVICES

Voluntary sector services are major service providers, especially those run by communities that are directly affected by mental distress, such as service user, family and Black and minority ethnic organisations. Voluntary agencies providing services enter into a contractual relationship with primary health and/or social services commissioners. Despite this the voluntary sector services remain independent and have sufficient funding and economies of scale to be sustainable. They provide a wide array of responses including clinical ones, often in collaboration with other types of agencies.

7.5 OTHER SECTORS

Education, employment and housing. Supported employment, supported education and housing support are collaborative, using expertise in those sectors as well as mental health expertise from the primary or specialist mental health sectors.

Public health. The agencies that promote well-being are structurally aligned and work closely with mental health, primary health, schools, workplaces and community organisations to coordinate their population based approaches with the individualised responses provided by services.

Community resources and agencies. Generic community resources are heavily utilised for the benefit of people with mental distress and loss of well-being

Human rights. Human rights agencies provide accessible information, advocacy and rights redress.

7.6 LOCAL LEADERSHIP GROUPS

All local agencies are accountable to a powerful, well-resourced district leadership group made up of all stakeholder groups, with strong service user, family, Black and minority ethnic groups and other local community membership. They investigate the needs and strengths of their local communities, as well as the outcomes for people using services. They use this information to advise commissioners and providers from the various sectors, who are genuinely accountable to them. The local leadership groups also direct the provision of independent information to communities on the availability and quality of local services.

8. SYSTEMS

8.1 POLICY

Policy is aspirational, achievable and aligned with other sectors. It is profoundly influenced by service users, families, and population groups that are most affected by mental distress such as young people, Black and minority ethnic groups.

International mental health policy comparison
http://www.cimh.org/downloads/handouts/N.Adams3%20.pdf

8.2 MEASURES

Government measures the well-being of the population and uses the results in the formulation of social and economic policy. Measures that indicate how a service is doing will continue to guide the quality of responses. They are simple and selective with an emphasis on leverage over coverage. This ensures the measures are easy to use and evaluate. However, measures have also raised the bar on minimum acceptable practice. Practice is externally evaluated on behalf of local leadership groups, and the results of the evaluations are explicitly connected to ongoing improvement processes and accountabilities. Measures include an emphasis on service user leadership, cultural responses, the reduction of compulsion, social inclusion, as well as cooperation and integration with other teams, agencies and sectors.

8.2.1 Recovery Outcome Measures

Recovery outcome measures are routinely used to evaluate personal recovery and the effectiveness of services.

Examples
Recovery Orientated System Indicators (ROSI)
www.power2u.org/downloads/pn-55.pdf (pp 81-90 & 229-243)

Recovery Orientated Services Evaluation (ROSE)
http://www.comm.psych.pitt.edu/finds/AACPROSEIII.pdf

Recovery Enhancing Environment Measure (REEM)
http://www.mhsip.org/2003%20presentations/Plenary/RidgewayPlenary.pdf

Recovery Self Assessment (RSA)
http://www.ct.gov/dmhas/LIB/dmhas/Recovery/RSAprovider.pdf

Scottish Recovery Indicator
http://www.scottishrecovery.net/content/mediaassets/doc/SRI%20ConfVers180407.pdf

Indicators of Recovery-Orientated Service System
http://www.paproviders.org/Pages/MH_Archive/Call_for_Change_110505.pdf (pp36-53)

8.3 COMMISSIONING

Commissioners have the right conditions and incentives to commission responses in a planned and future driven way, ensuring there is equitable provision of services for people in the populations they serve. They have the resources and flexibility to tailor funding for people with unusual sets of needs, to do direct payments, to fund jointly with other agencies, and to phase out traditional services while they introduce new ones.

8.4 DEVELOPMENT

Coordinated service development, workforce development and research at the national and local levels, help drive responses into the future. Existing services and workforces have been reoriented. New services and workforces are being developed.

Workforce development focuses on new workforces such as the service user, family and Asian workforces, as well as reorienting existing workforces. Education emphasises emotional competence reflective practice and self-care, as much as theoretical and practical competence. New or scarce occupational skills are acquired through education, such as addictions, trauma informed care, crisis support, peer support, recovery education, supported housing, education and employment, individual advocacy, working collaboratively, as well as service negotiation and navigation. There are also education programs for people who work outside the health sector with people with mental distress.

Service development dovetails with workforce development. The development of peer support services, recovery education services, supported housing, employment and education, advocacy services, and new home and community based acute services have been well coordinated in the different districts and with other development activities.

Research development both reflects and tests the values and assumptions services are based on. Research and evaluation informs and shapes workforce and service development efforts. The research world has become broadened with service users, families, Black and minority ethnic groups, and other traditionally excluded groups getting equitable access to research money. As a result, there is a broader base of methodologies and evidence to draw upon. Quantitative research and evidence continues, but qualitative research has equal credibility because it can incorporate the subjectivity and narratives of traditionally excluded groups. The newer qualitative research approaches look at evidence from the ground up, emphasising client-based evidence, practice and community based evidence as well as formal research based evidence.

8.5 INDEPENDENT OVERSIGHT

An agency or agencies, funded through health but outside the health line of accountability, will:

- monitor the systems of services and responses
- ensure information to communities on the availability and quality of services.
- provide national systemic advocacy by and for people with mental distress, and families.