Supporting recovery orientated services for people with severe mental illness

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Abstract

There is now wide agreement that people with severe mental illness can be adequately treated and cared for in the community, provided back-up hospital care is available when needed. Another important development has been the recognition that clinical treatment and care is insufficient for recovery and restoration of role functioning following illness onset, and must be supplemented by evidence-based practices in psychiatric rehabilitation. This article describes how allied health professionals can lead recovery oriented approaches that incorporate evidence-based forms of psychiatric rehabilitation. Family psychoeducation and supported employment are provided as examples of such evidence-based practices that require wider implementation.

Supporting Recovery Orientated Services for People With Severe Mental Illness

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There is now wide agreement that people with severe mental illness can be adequately treated and cared for in the community, provided back-up hospital care is available when needed. Another important development has been the recognition that clinical treatment and care is insufficient for recovery and restoration of role functioning following illness onset, and must be supplemented by evidence-based practices in psychiatric rehabilitation. This article describes how allied health professionals can lead recovery oriented approaches that incorporate evidence-based forms of psychiatric rehabilitation. Family psychoeducation and supported employment are provided as examples of such evidence-based practices that require wider implementation.

Keywords: psychiatric rehabilitation, supported employment, family psychoeducation, allied health professionals

The term 'recovery' has been increasingly used in mental health services and has been a guiding principle for mental health policy in countries such as the United Kingdom (Department of Health, 2001), Australia (Australian Health Ministers, 2003), New Zealand (Mental Health Commission, 1998), and the United States (New Freedom Commission on Mental Health, 2005). One of the biggest obstacles to implementing recovery-oriented practice has been the lack of clarity and agreement regarding what it really means in practice. Recently Davidson and colleagues (2006) from the United States and Chaplow (2008) from New Zealand explored and discussed the challenges associated with the implementation of a recovery approach. For example, challenges included beliefs that recovery-oriented care is implemented only through the addition of new resources and that recovery-oriented care increased providers' exposure to risk. They suggested that recovery requires reframing the treatment approach from the

professional's perspective to the person's perspective. Thus, the issue is not what role recovery plays in treatment but what role treatment plays in recovery. This shift in thinking has important implications for how clinicians conceptualise and deliver care and the degree to which it is effective and acceptable to the service user (Davidson, Connell, Tondora et al., 2006; Lloyd, Waghorn & Williams, 2008).

There are a number of key ingredients that practitioners need to deliver recovery-oriented practice in public mental health. These have been identified by several researchers (e.g., Borg & Kristiansen, 2004; Light & Tse, 2006) as openness towards clients, collaboration as equals, a focus on the individual's inner resources, reciprocity, and a willingness to go the extra mile. In the document, *The Journey to Recovery* (Department of Health, 2001) it is suggested that clinicians need to create an optimistic, positive approach to all people who use public mental health services. It goes on to say that 'the mental health system must support people in settings of their own choosing, enable access to community resources including housing, education, work, friendships — or whatever they think is critical to their own recovery' (p. 24).

The language and intentions of government policy (Department of Health, 2001) are congruent with the goals and values of allied health professionals, which focus on helping people to recover full active lives following mental illness onset. Hence, we recommend that allied health professionals (occupational therapists, psychologists, and social workers) start delivering evidence-based forms of psychiatric rehabilitation, namely: (1) supported employment (Bond et al., 2001; Bond et al. 2008); and (2) family psychoeducation (Pharoah, Mari, & Streiner, 2001); as two examples of psychiatric rehabilitation interventions based on substantial evidence (Bond & Campbell, 2008). This article first describes the components of what would be considered 'recovery-oriented' services and then focuses on how supported employment and family psychoeducation programs can be implemented by allied health professionals to improve the recovery and community participation of people with severe mental illness.

Recovery and Mental Health Services

People with mental illness face many social and economic barriers and find themselves excluded from many aspects of daily life that we take for granted (Department of Health, 2004; Lloyd, Tse, & Deane, 2006). This may include education and employment. Such exclusion can lead to social disadvantage, chronic poverty and social and economic marginalisation from the wider community. Government policy aims to address such disadvantage by promoting recovery rather than emphasising disability through mental health service systems.

Even with optimal mental health treatment and care, serious mental illness can lead to prolonged disability as a secondary consequence of illness. This is often noted even when treatment is relatively effective and residual symptoms are minimal (Davidson et al., 2006). Hence, even optimal treatment is insufficient to return people to premorbid levels of functioning. This calls for the provision of accommodations and supports that enable people with serious mental illness to lead safe, dignified and full lives in the community. Davidson et al. (2006) suggest that to capture the shift in practice required for this form of recovery it is necessary to identify and build upon each individual's assets, strengths, areas of health and competence to support the person in managing his or her condition. Recovery has been

described as more of a process than an outcome. It is generally recognised as a highly personal and nonlinear process that occurs throughout a person's life. It is nonlinear in the sense that people with mental illness experience various ups and downs or relapses over the course of the illness.

However, despite the unique experience of recovery there have been a range of shared processes and stages described (Andresen, Oades, & Caputi, 2003). Domains of recovery have also been identified (Lloyd et al., 2008). Many service user narratives and definitions of recovery include some of the following components: hope, empowerment, autonomy, personal responsibility, changes in personal identity particularly in relation to perceptions of mental health problems, greater meaning in life, and peer support (Andresen et al., 2003; Jacobson & Greenley, 2001; Secker, Membrey, Grove, & Seebohm, 2002). However, recovery-based practices have yet to make a significant impact on the working practices of the majority of mental health professionals. This is due to the fact that in many cases the dominant treatment framework focuses on the disability associated with mental illness (Lester & Gask, 2006), which can lead to problems in creating environments, structures and processes that encourage recovery in a way that makes sense to both clients and health professionals.

In a recovery-oriented system of care, people need to be included in decision-making and they should have a sense that services are targeted around their personal needs (Bonney & Stickley, 2008). A recovery-oriented system of care does not place responsibility solely on mental health services. Supporting people in their recovery requires the active participation of a variety of sectors including health, housing, income support, education, employment, and community agencies.

Mental health care and health systems do not always provide comprehensive or good quality services to users with mental illness. For example, a review of services provided to people with schizophrenia attending public mental health services found 38% received poor medication management and 52% inadequate psycho-social care (Young, Sullivan, Burnam, & Brook, 1998). People with mental illness receive a very low level of preventative health care (Salsbery, Chipps, & Kennedy, 2005) and only 31% of family members of people with mental illness receive even informal contact with mental health services (Resnick, Rosenheck, Dixon, & Lehman, 2005a).

Such care deficits are best addressed through inter-sectoral collaboration. In developing collaborations it is also important to avoid duplication, service gaps, and interventions that are too complex and disconnected. Given some of the issues around poor access to services, practitioners in mental health settings are often called upon to act as advocates for service users attempting to access services in other sectors. Stigma and the associated loss of personal power often means that service users' requests for assistance can be ignored or minimised. In addition, service users may lack the knowledge, confidence, assertiveness, stress tolerance, and persistence needed to get a satisfactory response from a particular service provider.

Thus, allied health professionals may need to intervene to varying degrees with government departments, landlords, medical systems, law enforcement, educational institutions or employers. This advocacy work can range from providing support and coaching to empowering the service user to navigate the various barriers to service access, through to support with essential tasks such as form completion, or direct contact with service providers. On occasions there may be a need to educate services about mental illnesses, or provide legal advocacy where there is systematic discrimi-

nation. Allied health professionals can link service users with various consumer-led organisations or other peak bodies that provide advocacy services.

Two very different but equally valid approaches to the treatment of people with serious mental illness have emerged. The scientific, objective, evidence-based approach to treatment and care emphasises external scientific reality, whereas the recovery approach emphasises the importance of subjective, lived experiences and the rights of people who are in recovery (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). According to Resnick et al. (2005b), evidence-based practices have the potential to provide the missing link for mental health services and mental health professionals so that they can cultivate a recovery orientation to treatment and care, while assisting service users to achieve important objective goals that are perceived as critical to their recovery. These goals may include participation in meaningful activity such as education and employment. The recovery orientation emphasises that responsibility for and control of the recovery process must be kept by the person who has the condition (Frese et al., 2001). Hence, a strong value is placed on individuals defining and pursuing their own life goals (Torrey, Rapp, Van Tosh, McNab, & Ralph, 2005).

Recovery and evidence-based practices are essential ingredients of high quality treatment and care for people with serious mental illness (Torrey et al., 2005). In a recent review of evidence-based practices for people with severe mental illness, Bond and Campbell (2008) specified six practices as evidence-based. These are assertive community treatment, family psychoeducation, illness management and recovery, integrated dual diagnosis treatment, medication management according to protocol, and supported employment. The evidence was particularly strong for supported employment and family psychoeducation. Given such a strong evidence base it is disturbing that there appears to be very limited implementation of these psychosocial treatments for people with serious mental illness (Dickerson, 2006).

In attempting to answer the question 'Are evidence-based practices recovery-oriented?', Davidson et al., (2009) first broadly define recovery-oriented practices as being 'person-centred, strengths-based, collaborative and empowering' (p. 329). They argued that supported employment would be considered highly recovery-oriented because of its 'focus on people's own interests and choices, and by virtue of its aim to help people to attain their own goals related to competitive jobs in the community' (Davidson et al., 2009, p. 329). Similarly, family psychoeducation approaches are also collaborative and seek to develop shared goals between consumers and their families. However, not all evidence-based practices were considered to be equally recovery orientated with assertive community treatment historically being considered somewhat more coercive. For this reason we focus particularly on supported employment and family psychoeducation as examples of evidenced-based practices which are also consistent with a recovery orientation.

Employment

Employment provides increased economic and social participation opportunities for people in their local communities. Provision of an income increases access to leisure activities such as sport, arts, or music. It offers potential for more lifestyle choices related to housing, transport and health care. Employment provides greater social status and empowerment (Linhorst, 2006). It provides more direct opportunities for social interactions with people not associated with the health care system. Recent

estimates of the proportion of people with severe mental illness in competitive employment in developed countries vary from 15–20% (Marwaha & Johnson, 2004; Waghorn et al., 2008). However, at least twice as many people with mental illness are considered capable of maintaining employment (e.g., Secker et al., 2002) and when asked, 70% of those with mental illness indicate they are interested in employment (Macias, Rodican, Hargreaves, Jones, Barreira, & Wang, 2006).

A wide range of strategies for increasing employment have been described (Killackey, Jackson, Gleeson, Hickie, & McGorry, 2006) but some are clearly more 'recovery-oriented' in philosophy and have better research outcomes than others. Supported employment refers to provision of individual support to help people with disabilities obtain and maintain competitive employment. A more specific version has been developed specifically for people with severe mental illness, and is termed Individual Placement and Support (IPS). This approach was developed by Professors Robert Drake and Deborah Becker in New Hampshire, United States (Becker, Smith, Tanzman, Drake, & Tremblay, 2001) and has the following key elements:

- the goal is competitive employment
- the focus is on commencing job searching within 4 weeks and commencing competitive employment as soon as possible. Pre-employment preparation and pre-vocational training are avoided
- employment assistance is closely coordinated with the provision of mental health treatment and care
- all services provided are based on clients' preferences and are used to build on clients' strengths
- assessment is ongoing once employment has commenced and is based on real employment experiences
- follow-on support is continued for as long as needed
- benefits counseling is provided to help people through perceived and real welfare traps (Bond, 1998; Bond, Drake, & Becker, 2008).

This approach has now been more extensively investigated than any other method in psychiatric rehabilitation (Bond 2004; Bond, Drake & Becker, 2008). To date, 16 randomised controlled trials (RCTs) and 6-day treatment conversion studies in nine developed countries have compared IPS to the best alternative approaches including local clubhouse programmes. Of these, 11 RCTs examined high fidelity (Becker et al., 2001) IPS services which reported outcomes averaging 60% employment, typically 2-3 times greater than the best alternative employment services (mean 24%). In addition to evidence for overall effectiveness, there is also evidence for four of seven core elements and emerging evidence that three other ingredients improve competitive employment outcomes (Bond 1998; 2004; Bond et al., 2008).

Family Education and Support

The recovery of people with mental health problems can be significantly affected by the level of their family's involvement in their rehabilitation (Webb, Pfeiffer, Mueser et al., 1998). Carers would like to be listened to, supported, and be involved in their relatives' care. Additionally, they require information about diagnosis, treatment and services, benefits and who to contact in an emergency. They also request advice on ways to respond to their relative and to develop additional coping skills (Stanbridge & Burbach, 2007). Despite families' expressed wishes to be included in their rela-

tive's care and the strong evidence base for specialist family interventions, these approaches are not yet routinely available (Stanbridge & Burbach, 2007).

Recent studies continue to suggest that family relationships and communication may be improved by concentrating psychoeducational support groups on objective and subjective burden by teaching relatives how to interact with their psychiatrically disabled relative (Cuijpers & Stam, 2002). Family psychoeducation has evolved into an evidence-based practice that has been shown to reduce relapse rates and facilitate recovery of individuals with mental health problems (Dixon, McFarlane, Lefley et al., 2001; Murray-Swank & Dixon, 2005). Family psychoeducation differs primarily in the ways it is delivered either as an individual family or multiple families in a group.

Multiple Family Group Therapy (MFGT) is a specific family intervention that was developed and investigated in the early 1990s. A landmark study conducted by McFarlane et al. (1995) showed that MFGT resulted in lower relapse rates that were maintained at 1- and 2-year follow-ups. However, access to MFGT and sustainability of such programs in practice has been found to be inconsistent (Kavanagh, Piatkowska, Clark et al., 1993). Further it has been found that for families of individuals with schizophrenia, only 31% have any informal contact with a clinician and only 8% attended a formal support program (Resnick et al., 2005a). Thus, access to formal family psychoeducation is relatively poor and allied health workers have a key role in addressing this service gap.

Broadly, family psychoeducation involves connecting with the family and working collaboratively in a nonblaming or judgmental way. In the early stages a treatment contract is often developed which helps to clarify the shared goals and plan between service user, family and clinician. Often family members will attend formal group psychoeducation sessions with other families. Such groups typically provide information about the nature of the illness, clarifying expectations of the client, setting limits, treatments, psychosocial supports in the community such as supported education or employment opportunities, and relapse prevention (Anderson, 1983). Multiple family groups (MFGs) also have structured problem-solving as a key intervention and skill set. One of the unique aspects of these psychoeducational MFGs is the added opportunity to learn from other families experiences and to experience support from other families in this process. In most cases the MFG provides a much-needed expanded support network (McFarlane, 2002).

Psychoeducation reduces family burden and supports both families and the individual with psychiatric disability. By strengthening family emotional and coping resources this allows them additional capacity to better support their family member with psychiatric disability. Families have the capacity to further facilitate community participation in a number of domains, be it by encouraging active participation or providing practical support such as transportation. Thus, by working collaboratively to reduce family burden, improve coping and problem-solving, the sustainability of broader social and community participation by people with mental illness is greatly increased.

The Role of Allied Health Professionals

Implementing evidence-based practices and recovery-oriented practices represents a challenge for allied health (Davidson et al., 2009). Many of the practices followed by allied health professionals may not be based on quality evidence. Rather, these practices

have evolved over time and may have been retained for factors other than evidence for effectiveness, such as service convenience and practitioner comfort. In addition, most allied health professionals were trained in traditional forms of vocational rehabilitation, which do not focus on the key elements of IPS (Waghorn, Lloyd, & Clune, 2009). Working in psychiatric rehabilitation may mean that allied health professionals will need to phase out existing nonevidence-based practices and plan and implement new services. Figure 1 summarises the process of combining recovery theory with practice in providing supported employment and family education and support services.

Implementing new evidence-based practices and recovery-oriented practices provides a range of new opportunities for allied health professionals. For instance, as an adjunct to IPS, there are opportunities to develop a range of add-on programs which show promise in terms of improving work performance and job retention once a person has commenced employment (Waghorn et al., in press). Some of most promising of these interventions include cognitive remediation (McGurk et al., 2007), work-related social skills training (Cheung & Tsang, 2005), and financial planning and benefits counselling (Bond, 2004).

There are a wide range of barriers that have been identified in attempting to implement supported employment models in practice (McAweeney, Jones & Moore, 2008). Broadly these have been categorised as consumer barriers (e.g., negative psychiatric symptoms), employer and cultural barriers (e.g., unfavourable labour market)
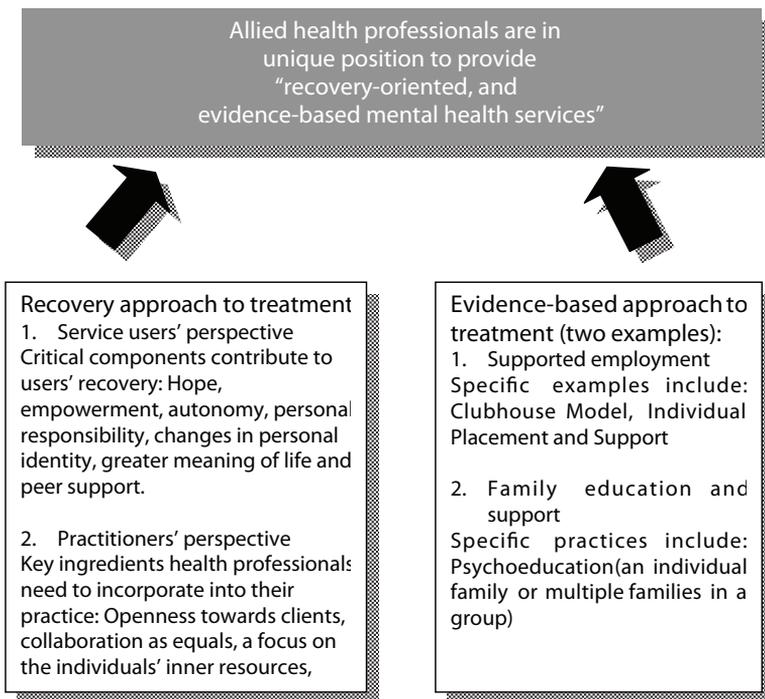

Allied health professionals are in unique position to provide "recovery-oriented, and evidence-based mental health services"

Recovery approach to treatment
1. Service users' perspective
Critical components contribute to users' recovery: Hope, empowerment, autonomy, personal responsibility, changes in personal identity, greater meaning of life and peer support.

2. Practitioners' perspective
Key ingredients health professionals need to incorporate into their practice: Openness towards clients, collaboration as equals, a focus on the individuals' inner resources,

Evidence-based approach to treatment (two examples):
1. Supported employment
Specific examples include: Clubhouse Model, Individual Placement and Support

2. Family education and support
Specific practices include: Psychoeducation (an individual family or multiple families in a group)

FIGURE 1

Combining recovery theory and practice: Provision of supported employment and psychoeducation services in public mental healthcare.

or clinical barriers (e.g., inadequate service resources) (McAweeney et al., 2008). A lack of service support (resources) is a major barrier which is difficult to address. However, even under these circumstances there are a growing number of evidence-based practices which are highly recovery-oriented. The strong focus of recovery-oriented services on clients identifying and attaining their own goals can be supported by individual mental health workers even in circumstances when other evidence-based approaches are not supported by a service. Goal setting has been identified as a vital component of service coordination and recovery support for people with severe mental illness (Clarke et al., 2009a). Goal setting has also been linked with the promotion of hope and personal meaning, two processes associated with recovery. Clarke et al. (2009b) suggest that assisting clients in achieving their goals will assist their subjective and psychological wellbeing and recovery will be enhanced. In the study conducted by Clarke et al. (2009b), findings highlighted the importance of a recovery framework of case-management targeting both the alleviation of symptoms and encouraging and monitoring personally meaningful goals in order to promote recovery from severe mental illness. Structured goal identification, planning and pursuit led to increased quality of goal plans (Clarke et al., 2009a). Further systematic task assignments (therapeutic homework) are recommended to help consumers take steps toward goal attainment and these systematic task procedures have been associated with improved treatment outcomes amongst people with severe mental illness (e.g., Kelly & Deane, 2009).

Family members play an integral role in the lives of many people with mental illness. Family involvement in treatment is a critical element of quality care (Murray-Swank, Dixon, & Stewart, 2007). Allied health professionals can conduct family psychoeducation groups and regularly meet with service users and their family and carers. Families routinely request information on basic facts about mental illness and its treatment, behaviour management skills, and the mental health system in order to cope better with their family member (Pickett-Schenk, Lippincott, Bennett, & Steigman, 2008). It is important that allied health professionals take a problem-solving approach to addressing shared goals of families and service users. Families may also be taught communication skills that reduce the critical and highly emotional communication styles that can emerge amongst family members (Murray-Swank & Dixon, 2005).

Conclusion

The importance of providing recovery-oriented treatment and care along with evidence-based practices in psychosocial rehabilitation is highlighted. There is a need to establish a complementary relationship between recovery and evidence-based practices. It must be noted, however, that this relationship is neither simple nor straightforward. We suggest that allied health professionals can provide interventions that promote recovery and full participation in the wider community. Both supported employment and family psychoeducation, are examples of two suitable evidence-based practices that could be more widely implemented to improve the recovery orientation of services, and to benefit service users and their families.

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