Recovery and Assertive Outreach

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Oslo, 9/2/11
Hallo
Overview

Background
Recovery definitions
Changing practice
Recent research and recovery-focused initiatives
The future of Assertive Outreach (G Shepherd, 2009)

We must radically change mental health services to make:
  paid employment …..
  and the involvement of people with ‘lived experience’ of mental health problems in the delivery of care …..

the over-riding organisational and cultural objectives.
Three phases of mental health service development

‘Deinstitutionalisation’ (1955 – 1995) moving out of the mental hospital

The ‘National Service Framework’ (1999 – 2009) – setting up services which are able to cope with the next generation of people with long-term and complex needs

The impact of ‘Recovery’ and ‘social inclusion’ – turning mental health services ‘upside down’
Reducing beds in the long-stay hospitals 1955 – 1995 (England and Wales)
Schizophrenia & outcomes

Kraepelin (1898): ‘Dementia praecox’: irreversible, progressive
Bleuler (Manfred, 1974): 20% complete remission, further 1/3 good social outcome
Harrison et al (2001): 20 year follow up 15 countries: 1/6 fully recovered. Late recovery in significant minority

Recovery happens!
Reducing beds highlighted some new problems ….

Lack of effective alternatives to acute admission and intensive community follow-up, particularly for those at risk if they disengaged from services.

The squeeze on beds raised the thresholds for inpatient admission, increasing levels of disturbance (including violence and aggression).

This was exacerbated by increasing numbers of patients with dual diagnosis (substance misuse) linked to a new range of highly potent street drugs, particularly cannabis, but also heroin and crack cocaine.

There were also a number of highly publicised incidents where members of the public were attacked by ‘mental patients’ in the community. This reinforced negative stereotypes, enhanced public fears and led people to conclude that ‘community care’ had failed.

Required the establishment of specialist assertive outreach teams in every locality to reach out to those who are difficult to engage and at risk if they fall out of follow-up

Also required the establishment of specific crisis resolution and home treatment services as part of a new set of responses for people at risk of admission

Encouraged the development of early intervention teams, aimed at young people (age 15-35) with first-episode psychosis.

Promoted user and carer involvement and ‘choice’ at all levels in services
How do we move from services which essentially provide a transition from institutional living to life in the community and achieve real community integration?

Tackling social exclusion

Addressing stigma

Addressing cultural and historical disadvantage

‘Recovery’ - a new rationale for mental health services
Social exclusion - what are the indicators? (SEU, 2004)

Less than a quarter of adults with long-term mental health problems are in paid employment (lowest rate for any disabled group)

People with MH problems have more than double the risk of losing their jobs

One in four tenants with mental health problems likely to be in serious rent arrears, they are also three times more likely to try to cut down on basic utilities (gas, electricity, water, telephone)

i.e. mostly associated with poverty. (Adults in the lowest 20% of incomes are twice as likely to develop MH problems, compared with those of average income).
Large group exercise: the difference between traditional and recovery orientated mental health services
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What is ‘Recovery’?

Youtube clip, Rachel Perkins
http://www.youtube.com/watch?v=T_lalloj1Hs
What is ‘Recovery’?  
(Anthony, 1993)

[Recovery is] “…. a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles… a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness…”

i.e. It is about achieving a different relationship with your ‘illness’, in which it is integrated into your identity, but does not dominate ....

It is about ‘building a life’, not just a new way of controlling symptoms

This means discarding the (generally low) expectations of professionals and pursuing user-defined goals and priorities.....

It implies a new relationship between service users and professionals (and a new attitude towards ‘risk’ and ‘risk management’).
‘The goal of recovery is not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human’ (Deegan, 1996).
Elements of Recovery
(after Andresen, Oades & Caputi, 2003)

Finding and maintaining hope – believing in oneself; having a sense of personal agency; optimistic about the future

Re-establishing a positive identity – finding a new identity which incorporates illness, but retains a core, positive sense of self

Building a meaningful life – making sense of illness; finding a meaning in life, despite illness; engaged in life

Taking responsibility and control – feeling in control of illness and in control of life
Users’ views
(from Brown and Kandirikiriria, 2007)

“Two or three years ago I realised that you really could recover…. I thought that once you had it, that was it – but you can recover. I find that quite an amazing fact…”

“I have taken ownership of my illness and I take responsibility for what I do and do not do. I don’t let it control me…… It’s not the whole of my life, it’s just a part of my life now…”

“The hardest thing about having a mental illness is the feeling that you’re constantly taking, that people are always giving to you, that people are always supporting you…..Recovery has been about actually looking at ways I can give back to other people that I care about…

“I definitely want to work in something that I feel I’m contributing … I feel like I have a lot of untapped potential and if I can stay well I can make something of my life. I don’t want not to achieve anything with my life…”
Professional views

‘Any services, or treatments, or interventions, or supports must be judged in these terms - how much do they allow us to lead the lives we wish to lead?’ (Repper & Perkins, 2003).

‘Increasingly, services (must) aim to go beyond traditional clinical care and help patients back into mainstream society, re-defining recovery to incorporate quality of life – a job, a decent place to live, friends and a social life’ (Appleby, 2007).

‘It seems hard to disagree with the proposition that recovery should be the guiding purpose for future mental health services. For what are we and our services doing if we are not supporting individuals and their families in a process of personal recovery? It is equally clear that by no means everyone is comfortable with embracing the ‘recovery agenda’” (Roberts & Hollins, 2007).
Exercise

Professional anxieties about a recovery approach
The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation (what recovery isn’t)

Larry Davidson (2006)

- recovery is old news,
- recovery-oriented care adds to the burden of already stretched providers,
- recovery involves cure,
- recovery happens to very few people,
- recovery represents an irresponsible fad
recovery happens only after, and as a result of, active treatment
recovery-oriented care is implemented only through the addition of new resources
recovery-oriented care is neither reimbursable nor evidence based, recovery-oriented care devalues the role of professional intervention, recovery-oriented care increases providers' exposure to risk and liability.
Recovery: Why is it so radical?

It means changing the priorities and objectives of traditional mental health services ……

……… putting personal and social goals above clinical outcomes (improved clinical status becomes the means to this end)

It means really putting users’ views at the centre of our services

This means changing the power relationships between service users (and their families) and professionals

It therefore has major implications in terms of both individual practice and organisational culture
So, how can recovery be achieved? (Sainsbury Centre for Mental Health, 2008)

Changing practice

Changing cultures

Changing the workforce
Exercise- working with a recovery style

Work with the person sitting next to you. Find examples of practice which you would describe as recovery orientated. Feed back one to the main group.
Changing practice - 10 ‘Top Tips’ for recovery oriented practice (Shepherd, 2007). Did I ......

.... actively listen and help the person make sense of their mental health problems?

.... help the person identify and prioritise their own recovery goals?

.... demonstrate a belief in the person’s own strengths and resources?

.... identify examples from ‘lived experience’ (your own or others) to inspire and validate these hopes?

.... pay particular attention to goals which take the person out of the ‘sick role’?
Changing practice (contd.)

Did I …..

…. identify non-mental health resources – family, friends, neighbourhood contacts, etc. – relevant to the achievement of these goals?

…. encourage self-management of mental health problems by providing information, reinforcing existing coping strategies, etc.?

…. discuss what the person wants in terms of therapeutic interventions, respecting their wishes wherever possible?

…. behave at all times so as to convey an attitude of respect, a desire for equal partnership, and a willingness to ‘go the extra mile’?

…. while accepting that the future is always uncertain, continue to express support and maintain HOPE?
Changing cultures

New models for effective leadership – open, honest, uncertain

New processes for recruitment and selection of staff

New HR methods – particularly re Occupational Health

New criteria for the management of individual practice

New emphasis on user (and carer) feedback (e.g. ‘Patient Survey’ results, ‘quality of therapeutic relationships’, etc.)

New ways of thinking about outcomes (‘social’ v. ‘clinical’) and new methods of routine outcome measurement

New ‘performance targets’ for trusts in terms of improving quality of experience, delivering social goals, achieving recovery focus (e.g. Dinnis et al., 2007 on DREEMs)
Changing the services

This means creating a new kind of organisation where the user ‘voice’ is central to the whole organisation’s rationale.

This implies challenging professional positions of power and authority – not ignoring them, but placing them in a new context.

It implies a considerable input in terms of training – ideally led by service users.

It will also require organisational (cultural) change and this may mean a reshaping of the workforce.
Some recovery oriented approaches:

1. Self directed support/personalisation

‘The biggest change since community care: a redesign of the social care system, ‘professional gift’ model to ‘citizenship’ model

Shifts control over services to service user

Premise: people do better if they control their own care.
Self directed support/personalisation

Needs assessment generates points & money available, leads to support plan.

Review by professionals re: quality & outcomes

Examples: family carers, music lessons, holidays, accommodation support
The ‘Individual Placement and Support’ (IPS) model (Becker, Drake & Concord, 1994)

7 key principles

Competitive employment is the goal (whole or part-time)

No selection criteria, beyond expressed motivation, i.e. accessible to all who want to work

Focus on consumer preference – ‘fitting the job to the person’

Based on rapid job search and placement. Minimises pre-employment assessment and training - ‘place-then-train’, not ‘train-then-place’

Relies on close working between employment specialists and clinical teams

Provides individualized, long-term support with continuity

Includes access to expert Benefits counseling
Outcomes from IPS *versus* traditional models (Latimer, 2008)

Percentages of clients who obtained competitive work in RCTs of SE (or pre-IPS) and IPS

- SE or pre-IPS
- Preliminary results

(Adapted from Gary Bond)
Lessons from the IPS research (so far)

It doubles the chances of successful return to work, but not for everybody – a proportion remain unmotivated or unable to maintain open employment.

Timing is critical, need to start as quickly as possible - hence concentrate on early intervention services?

IPS gets people back to work quicker, but there may be problems with job retention. Is this important?

Inflexibility in the Benefits system and general employment factors influence outcomes, but this may be partially offset by part-time working and the use of ‘permitted earnings’
Contemporary models of supported accommodation: what people want

Service user dissatisfaction with traditional, shared, supported accommodation models, want decent, non-ghettoised, independent housing, flexible support when needed (Rose & Muijen, 1997)

People want: privacy, independence, own front door
Core & cluster/high dependency schemes popular, able to meet need (Carling, 1993, Middleboe et al, 1998), improve Q of L
Fits with recovery model
Individual care packages

Characteristics: service user has tenancy, with practical + emotional support provided by care workers, via private provider agency. Generally flat or shared house.

Funded via health/social services panel

Overseen by specialist mental health services +/- commissioners
Housing First - a new idea

Tsemberis et al (2004), USA. Random allocation of 208 participants with severe mental illness and substance misuse to a housing programme immediate housing without expectation of psychiatric treatment, compliance or abstinence from substance use, compared with transitional housing, requiring compliance and sobriety.

No differences in psychiatric symptoms or substance abuse.

Results challenge the common practice of linking access to housing with a requirement to accept treatment and sobriety.
Recent AO research- does engagement and the therapeutic relationship matter?
A mixed methods analysis of interventions delivered by assertive community treatment and community mental health teams (the REACT trial).


No differences on any measure of inpatient service use (any admission, number, MHA, PICU)
No differences in symptoms, social function, needs, quality of life, substance misuse, adverse events, medication adherence
AO participants had 3x more face to face contacts with staff than CMHT participants but this was less than weekly
AO recipients better engaged, less likely to be lost to follow-up and more satisfied with service
ACT less coercive than standard care


Very little use of coercive approaches e.g. outpatient commitment, financial control

Evidence of wide range of collaborative approaches that promoted psychoeducation and engagement


Service users’ perceived coercion reduced more for ACT than CMHT clients

Fewer coercive strategies used by ACT than CMHT staff
Priebe, S., Watts, J., Chase, M et al.
Processes of disengagement and engagement in assertive outreach patients: qualitative study.

- Service users reported that a poor therapeutic relationship was most important factor associated with disengagement from AO
- Engagement was promoted where there was not a focus on medication and where service users felt they were in an authentic partnership and being listened to

- Therapeutic alliance is one of the most powerful predictors of outcome in psychotherapy
- Outcomes include social functioning, global improvement, drug use
- Meta-analyses suggest around 25% of outcome can be attributed to therapeutic alliance

Paucity of literature on therapeutic alliance in schizophrenia
Most measures used to assess therapeutic alliance developed for psychotherapy clients
Measures generally assess single relationship, not team
Associations found with: medication adherence; satisfaction; self-rated symptoms and social functioning; quality of life; inpatient service use
Video: Pat Deegan

http://www.youtube.com/watch?v=2AZ3OImjXLs
http://www.youtube.com/watch?v=vmdZo-G1DFE&feature=related
http://www.youtube.com/watch?v=IWCJRrXtSLc
Measuring recovery in schizophrenia

The challenge: ‘make the important measurable, not the measurable important’ (Roberts & Wolfson, 2004).

Measures: The Mental Health Recovery Measure (MHRM; Young & Ensing, 1999) assesses three phases of recovery: overcoming sickness; discovering and fostering self-empowerment; and striving to attain overall well-being and reach new potentials.

The Recovery Assessment Scale (RAS; Corrigan et al, 1999): based on the narratives of service users and assesses personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others and symptom coping.


Recovery has been found to be inversely related to symptoms and positively correlated with quality of life and empowerment (Corrigan et al, 1999).
Resources


100 ways to support recovery, Slade, Rethink, 2009

Enabling recovery. Roberts et al, 2006

Takk for oppmerksomheten!

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