Second Edition

Care Planning in Mental Health

Promoting Recovery

Edited by
Angela Hall, Michael Wren and Stephan D. Kirby

WILEY Blackwell

Contents

Section 2 Managing

Chapter 8 The Legal and Ethical Landscape

Chapter 9 Enabling Risk to Aid Recovery

Dedicated to:

Nigel (RIP)

Care Planning in Mental Health

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Edited by Angela Hall, Michael Wren and Stephan D. Kirby
All editors at:
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Chapter 1

Introduction: The Emergence of Recovery as a Key Concept

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> *We shall never cease from exploration. And the end of all our exploring*
> *Will be to arrive where we started. And know the place for the first time*
>
> T.S. Eliot (*Little Gidding*)

At the end of the first edition, we left you with two rhetorical questions that arose as a consequence of producing that text:

> *How different would services look if their primary focus was to enable people to use and develop their skills, make the most of their assets and pursue their aspirations?,*

and

> *Would this not change, for the better, the experience of using services, and the relationship between workers, and those whom we serve?* (Repper & Perkins, 2003:11)

In this second edition, we hope to address these questions and in doing so raise your awareness of wider issues and concepts so that you are better informed to decide if you want to be agents of and for the organisation or champions of future change.

Building upon the strengths of our previous book (still available at all good book sellers, Blackwell Publishing website and Amazon), this current text utilises a more conceptual and person-focused approach that will enable the reader to plan for the future, and to challenge political, medical, social and professional identity issues. It is worth pointing out that even though this is a second edition, we have not simply, as is traditional, taken the original chapters and updated them; rather, we have preferred to reflect the developments and advances in mental health care and recovery. We felt it was important that the book reflected the notion that care planning is not simply APIE; rather, it is a move from a professional model focus to the active promotion of the person and their individually constructed narrative. So by engaging with the person's resilience, reserves and inner resources, we are able to focus recovery work around the individual, their story, hopes, dreams, skills and strengths rather than the symptoms of their mental distress (Saleebey, 2009). To address this paradigm shift, our stance within this text openly acknowledges, introduces and applies a variety of differing concepts and ideas underpinning the fact that we best serve people on their journey to recovery by collaborating with them (White & Epstein, 1990).

The reader will find (and we make no apologies for this) that there is no – or very little – explicit mention of APIE as a care-planning process. Whilst this is inherent within the text, it is not the primary focus of this work; rather, we are offering the reader insights into ways of approaching and understanding an alternative underpinning philosophy when implementing care planning in mental health. The structures of Care Planning are well documented and established within the delivery of mental health care; what we hope the reader will gain from this text is a more enlightened and person-focused way of approaching the activities involved in

planning collaborative, interprofessional and person-centred care that gives the person with the mental health problem the hope, optimism and opportunity to express their own desires, aspirations and potential that will enhance their journey on the road to recovery.

In the first edition, we attempted to address the issues around recovery as a concept and its application within the care-planning process. However, we were directed by the traditional and dominant frameworks that pervade mental health: such as Care Programme Approach (CPA), a range of 'new' legislations (e.g., the then proposed amendment of the Mental Health Act 1983 (DoH, 1983), the influences of numerous medical model-focused clinical practice guidelines and not forgetting the APIE of the prescriptive Nursing Process. The dominant culture within mental health has prevented professionals from challenging and progressing recovery-focused practice and has made them into (despite their good intentions and desires) passive recipients of the status quo which is shrouded in new terminology and contemporary rhetoric. They become afraid to deviate from this to embrace the recovery concepts as these are often questioned by the organisation as they are not seen to be part of the corporate vision and identity, which is invariably based upon financial requirements and popular trends with no thought for the people receiving and centrally involved in the care. In policy terms, mental health needs to be more concerned with health and wellbeing as well as providing direct support to people to enable them to function as full citizens in their communities (DoH, 2007). 'Increasingly services aim to go beyond traditional clinical care and help patients back into mainstream society, redefining recovery to incorporate quality of life – a job – a decent place to live – friends and a social life' (Appleby, 2007).

We are conscious that there have been major changes in mental health in the years between these two editions. These encompass a refocusing of organisational structure, culture and delivery models. We have continued to see legislative documents and dictates published as well as the further move into community care and, in some cases, even the rebirth and refocus of inpatient provision. Most importantly is the drive, through education and into services, towards the further promotion of the recipient of mental health services being accepted as human beings and equal partners.

This has reawakened the emphasis on 'The Person' (their essence, attributes, uniqueness and individuality and all the factors that exert an influence on personhood) and the hopeful demise of interchangeable labels of stigma, discrimination and depersonalisation. It is obvious that there are, and will be, difficulties and resistances to the professional's acceptance and adoption of these 'new' (though not really new, just old ideas rebranded and repackaged) ways of perceiving the new mental health landscape. There are resistors from all sides, the need to meet organisational targets (the ubiquitous audits and quotas which appear to (and indeed *do*) drive and underpin service provision), both the personal and organisational paranoia of litigation that appears to underpin service delivery today; and the need to have every meeting with the person with the mental health problem; every action; assessment; intervention and interaction recorded and rated on a sliding scale of risk and the appropriate risk management strategies created accordingly. There are ever-decreasing timescales and ever-increasing caseloads that services have to contend with, as well as the change in funding and the move towards a market-led provision with GP fund holding imminent; resistance from individuals and organisations abound. Organisations are being driven by

‘New Managerialism’ (Hafford-Letchfield, 2009) which relies on targets and outcome-driven agendas and where the illusion of being an involved customer is created and maintained, but in reality, people are merely a commodity of the market place. Recovery provides a new rationale for mental health services and has implications for the design and operation of mental health services and partnerships between health, social services and third-sector organisations (Shepherd *et al*., 2008).

Whilst in the latter half of the last century, recovery was thought to be an alien concept (Coleman, 1999), it is now firmly on agendas; indeed, it *is* the agenda. Work started by Romme and Escher in their seminal work with voice hearers started a paradigm shift (Romme & Escher, 1993) and it is up to everybody to continue that work until the shift is complete. The Hearing Voices Network, informed by this work of Romme and Escher, works positively with people’s experiences of hearing voices (Rogers & Pilgrim, 2010). Rather than trying to obliterate the voices, as a traditional symptom-based approach might do, this user-led initiative attributes meaning to voice hearing. This offers alternative means of coping with voices that may at times cause their recipients distress. Recovery as an idea, a concept and a care focus has now come of age and its importance has been recognised and acknowledged and it provides a new rationale for mental health services (Shepherd *et al*., 2008). It is based on the notions of self-determination and self-management and emphasises the importance of ‘hope’ in sustaining motivation (Shepherd *et al*., 2008). It has become the key principle underlying mental health services across the world, for example, New Zealand (Mental Health Commission, 1998), the United States (Department of Health and Human Services, 2003), Australia (Australian Government, 2003), Ireland (Mental Health Commission,

2005), Scotland (Scotland Government, 2006) and in England (DoH, 2001, 2006, 2007).

Ron Coleman (Coleman, 1999) tells us that there is a common joke amongst people with mental health problems that they all understand, ‘What is the difference between God and a Psychiatrist? Answer: God does not think he is a Psychiatrist’. He continues that there is another major difference between God and Psychiatrists: while ‘God created the world in 7 days, a Psychiatrist can change a person’s in little under an hour’ (Coleman, 1999:7). It is no surprise therefore that the road to recovery is difficult and fraught with dangers and traumas, but the road to illness is surprisingly easy – far too easy (Coleman, 1999:7).

It must be pointed out though that this somewhat scathing attitude towards psychiatry and psychiatrists was taken from a number of years earlier in Ron’s career towards ‘product champion and leader’ for voice hearing and trainer for voice hearers. This was a period when clear, distinct lines of battle were drawn between professionals and purveyors of psychiatry and the population that were deemed to be in need, usually against their free will and without consultation, of such disempowering actions. However, as years have passed and with the advent of mental health, so has the culture and climate of recovery. The culture and infantilising nature of psychiatry is diminishing, and partnership working and engagement and empowerment from a recovery framework is growing. Ron and many of his contemporaries now collaborate closely with psychiatrists; indeed, some of his working partners and trainees are psychiatrists. Traditionally, the medical model has served as a means of deflecting attention away from the person and their lived experience(s). None of this is a condemnation of the medical model and psychiatry (as opposed to mental health) per se, but acknowledges the fact that there are limitations to this particular way of

representing the experience(s) and problems of living for the person with mental health problems (Barker, 2001). Nor does it, or should it, promote the exclusion of the medical model from the mental health care arena or from the delivery of a person-focused approach to mental health care recovery. Rather, it has its place as does every other approach and discourse; there are times when paternalistic decision making has to occur without the person's involvement and for their best interest. Similarly, there are times, as the person progresses through the phases of recovery, where this approach has to take a back seat and allow the more person-centred, empowering and self-management approach to occur. One that affords the person more growth opportunities towards, and along, an empowering, person-centred approach to recovery within mental health recovery.

But what is recovery? It has been said (Coleman, 1999) that professionals define recovery as maintaining a person in a stable condition, regardless of issues such as adverse effects of medication or even the expressed wish of the person. However, from the person experiencing the mental health problems, recovery is a personal construct, one that is defined by the person themselves, based upon their own experiences and resources. Importantly, the essence of clinical recovery is based upon the premise that clinical recovery occurs because of the effectiveness of the clinical treatment. It is this aspect of recovery, effective (person-centred) treatment that this book is hoping to capture and promote. Recovery is also seen (Anthony, 1993) to be '…a deeply personal, unique process of changing one's attitudes, values, feelings, goals and/or roles…a way of living a satisfying, hopeful and contributing life even with the limitations caused by the illness…the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (p. 17).

Shepherd *et al*. (2008) offer what they propose to be the key themes of recovery, these being:

1) **Agency** – gaining a sense of control over one's life and one's illness. Finding personal meaning – an identity which incorporates illness, but retains a positive sense of self;

2) **Opportunity** – building a life beyond illness. Using nonmental health agencies, informal supports and natural social networks to achieve integration and social inclusion;

3) **Hope** – believing that one can still pursue one's own hopes and dreams, even with the continuing presence of illness. Not settling for less, that is, the reduced expectations of others.

(Shepherd *et al*., 2008)

These three overarching themes of recovery were taken on board by the Devon Recovery Group and resulted in the following Principles of Recovery (see Box 1.1). This resulting set of principles (Davidson, 2008) clearly demonstrates an active collaboration of the mutual roles, responsibilities and resources which aim to promote the person, their experience(s) of mental health problems and also reflect a desire and drive to capture the essence of their recovery. These are seen, by the editors, as being key concepts of 'making recovery a reality' (to borrow a phrase from the Sainsbury Centre) and through which we discover the person, their life and celebrate their diversity for, and opportunities to, change. These principles were the inspiration behind, and also formed the underlying belief system for, the development of this text.

One of the central and primary principles of recovery is the notion that it does not necessarily mean cure (clinical recovery); rather, it acknowledges the unique journey a person goes through when building a life beyond mental illness (social recovery) (Shepherd *et al*., 2008). People have

to come to terms with the trauma that the occurrence of mental health symptoms can have on their lives and incorporate these experiences into a new sense of personal identity (Larsen, 2004).

Box 1.1 The principles of recovery.

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems;
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness;
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward;
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all';
- The helping relationship between clinicians and patients moves away from being expert/patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be 'on tap, not on top';
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services;
- Recovery is about discovering – or rediscovering – a sense of personal identity, separate from illness or disability;
- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity;
- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience;
- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

(Davidson, 2008; Shepherd *et al.*, 2008)

Such traumas can only be resolved if the person can discover – or rediscover – their sense of, and ability to action, personal control (agency) and thus gain a belief in