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Collaborative Recovery: An integrative model for working with individuals who experience chronic and recurring mental illness

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Abstract

Objectives: Recovery is an emerging movement in mental health. Evidence for recovery-based approaches is not well developed and approaches to implement recovery-oriented services are not well articulated. The collaborative recovery model (CRM) is presented as a model that assists clinicians to use evidencebased skills with consumers, in a manner consistent with the recovery movement. A current 5 year multisite Australian study to evaluate the effectiveness of CRM is briefly described. Conclusion: The collaborative recovery model puts into practice several aspects of policy regarding recovery-oriented services, using evidence-based practices to assist individuals who have chronic or recurring mental disorders (CRMD). It is argued that thismodel provides an integrative framework combining (i) evidence-based practice; (ii) manageable and modularized competencies relevant to case management and psychosocial rehabilitation contexts; and (iii) recognition of the subjective experiences of consumers.

Keywords

mental, chronic, experience, who, collaborative, working, model, recovery, recurring, illness, individuals, integrative

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Keywords: Chronic mental disorders; collaborative recovery model; treatments

Abstract

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1. INTRODUCTION

The collaborative recovery model (CRM) translates a recovery vision of mental health to specific principles and practices, which can in turn be used to define related practitioner competencies that are shared across professional disciplines in mental health.[1] The CRM synthesizes evidence-based practices in community mental health contexts with broader evidence based on constructs consistent with psychological recovery. Through its emphasis on nurturing hope, supporting autonomy and subjective goal ownership of consumers, CRM is explicitly configured to be consistent with the recovery vision of both consumers and services. Readers should note that collaborative recovery is a different intervention and research programme than collaborative therapy.[2]

A substantial body of empirical research identifies effective psychosocial interventions in the treatment of psychoses, including family intervention, social skills training, cognitive–behavioural therapy for psychosis, case management, psychosocial rehabilitation and supported employment.[3–8]

Underpinning the effective implementation of these and other evidence-based interventions is a core set of evidence-based procedures, including research on the relationship between working alliance and outcomes, motivation enhancement, the relationship between goals and well-being, and the effect of homework on outcomes.[9–12] Moreover, there is mounting

evidence from the recovery literature, which emphasizes the importance of hope, autonomy, self-determination and consumer participation when developing evidence-based approaches.[13,14] The CRM draws evidential support from these sources in developing its principles and practices.

1.1 RECOVERY MOVEMENT IN MENTAL HEALTH

The term 'recovery' has become widely used in mental health policy and service delivery contexts and is in danger of losing specific meaning.[15] The CRM does not assume that recovery will necessarily mean a full return to a former state of health or functioning.[16] Instead, CRM emphasizes the development of new meaning and purpose as the person grows beyond the catastrophe of mental illness.[17]

1.2 COLLABORATIVE RECOVERY MODEL

The CRM consists of two guiding principles and four components, totalling six training modules. Four specific protocols for clinicians to follow are motivational enhancement (ME), needs assessment, collaborative goal technology (CGT) and homework assignment. Clinicians require specific knowledge and skills to follow these protocols, and particular attitudes to work within a recovery orientation. The six competencies, as illustrated in Table 1, involve the flexible use of these protocols and the associated knowledge, skills and attitude. The six competencies correspond to the six modules of the collaborative recovery training programme.

Table 1. Modules of collaborative recovery training programme

Module	***Knowledge domains***	***Protocol, skills and attitudes***	***Competency***
Recovery as an individual process (guiding principle 1)	Psychological recovery as an individual process involving: (i) hope; (ii) meaning; (iii) identity; and (iv) responsibility	Skill: understand and describe current interactions in terms of a consumer's recovery process related to hope, meaning, identity and responsibility. Attitude: hopefulness towards consumers' ability to set, pursue and attain personal goals that facilitate recovery	Employs the principle that psychological recovery from mental illness is an individualized process in all interactions and across all protocols
Collaboration and autonomy support (guiding principle 2)	Working alliance Barriers to collaboration Autonomy	Skill: develop and maintain a working alliance Attitude: positive, towards genuine collaboration	Employs the principle that maximum collaboration and support of autonomy should be demonstrated in all interactions and across all protocols

Table 1. Modules of collaborative recovery training programme

Module	*Knowledge domains*	*Protocol, skills and attitudes*	*Competency*
Change enhancement (component 1)	Motivational readiness Importance and confidence Stage of health behaviour change Cognitive capacity	Protocol: motivational enhancement Skill: use motivational interviewing appropriate to stage of change Attitude: take partial responsibility for interactional and environmental aspects of motivation	Enhances recovery enhancing change by skillful use of motivational interviewing and consideration of cognitive capacity, in a collaborative manner
Collaborative needs identification (component 2)	Unmet needs and motivation Negotiated need	Protocol: CANSAS Skill: flexibly use CANSAS as a precursor to goal setting Attitude: maintain negotiated approach	Flexibly uses a negotiated approach to needs assessment using the CANSAS that assists motivation of the consumer leading to goal setting and striving
Collaborative goal striving (component 3)	Personal recovery vision Goal identification, setting and striving Meaning/manageability trade-off Autonomous goals Prevention and promotion goals Proximal and distal goals	Protocol: CGT Skill: elicit meaningful vision and manageable goals Attitude: persistence with principles	Persists collaboratively with the CGT to assist recovery by way of the development of an integrated meaningful personal recovery vision and manageable goals, which provide a broader purpose for specific homework tasks
Collaborative task striving and monitoring (component 4)	Homework Generalization and reinforcement Self-efficacy Self-management Responsibility	Protocol: review, design and assign Skill: flexibly review, design and assign tasks related to goals Attitude: value between-session activity	Systematically and collaboratively assigns homework tasks, and monitors progress towards task completion and goal progress, to enhance self-efficacy of consumer

1.2.1 Guiding principles

Recovery as an individual process

The CRM champions the individuality of the lived experience and the ownership of the recovery process by the consumer. A recent review by Andresen *et al*., of 28 experiential accounts, 14 articles by consumers and eight qualitative studies, identified four common recovery processes: (i) finding hope; (ii) redefining identity; (iii) finding meaning in life; and (iv) taking responsibility for recovery.[18] The personal manner in which a mental health consumer experiences these processes is highly variable.[19] The CRM respects the personal journey and self-determination of consumers.

Collaboration and autonomy support

Although a recovery process is personal, it need not be isolated. The CRM recognizes the benefit of an effective working alliance. Hence, the term 'collaborative recovery': a dialectic between a person who is recovering and one or more persons assisting this process.

A substantial psychotherapy research literature has consistently found a significant relationship between the strength of the working alliance and mental health outcomes.[20] However, a recent review of therapeutic alliance in case management of serious mental illness showed that evidence for an impact on outcomes remained sparse, despite a recent increase in studies examining these issues.[21]

The term 'autonomy support' is drawn from self-determination theory, and involves three components: (i) taking the perspective of the consumer; (ii) providing choice to the consumer; and (iii) providing a rationale to the consumer for what is occurring. Sheldon *et al*. emphasize that being autonomous or self-determined does not mean being isolated or independent of others.[22]

1.2.2 Collaborative recovery model components

Change enhancement

The change enhancement incorporates ME and the recognition of cognitive capacity. This takes into account the motivational and cognitive capacities that people with chronic and recurring mental disorders, particularly schizophrenia, may experience as barriers to their recovery process.

Motivational enhancement (originally termed 'motivational interviewing') is a style of counselling and a set of techniques that aims to engage and motivate the individual towards change.[23] The use of motivational enhancers recognizes that change occurs at different rates for different people, and may involve several cycles through the different stages of change before individuals gain some mastery in terms of active self-management of their health and well-being. Motivational enhancement involves the clinician helping the individual to identify advantages and disadvantages of specific existing behaviours and planned behaviours.

The cognitive deficits experienced by people with chronic and recurring mental disorders, particularly schizophrenia, are well documented.[24] The CRM recognizes the limitations that cognitive capacity place on the identification and pursuit of appropriate recovery-related goals by an individual. Clinicians are encouraged to adapt their practice to optimize communication and collaboration with the consumer, by taking cognitive capacity into account.

Collaborative needs identification

The CRM recognizes that unmet needs are a key source of motivation for mental health consumers and hence are important to identify. The CRM adopts a negotiated approach to need, using measures such as the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) as part of needs assessment and as a precursor to collaborative goal setting.[25]

Collaborative goal setting and striving

Collaborative goal setting within CRM is one way in which self-determination and consumer ownership of the recovery process is operationalized. There is strong empirical support for the benefits of goal setting and related striving for human goal attainment, and a great deal is known about the nature of goals that may assist recovery in a mental health context.[26] Collaborative goal technology is a modified version of goal attainment scaling that is designed to operationalize goal-related processes central to CRM.[27,28] Goals within CGT may be promotion goals, aiming at achieving a desired outcome such as employment, or prevention goals, aimed at preventing an undesired outcome such as relapse or physical disorder.[29] Both types of goal are common, although they do involve different motivational processes.[30]

Little's concept of the 'meaning and manageability trade-off' within goal striving underpins CGT.[31] When individuals set and strive towards goals, they balance the meaningfulness of the goal with its perceived manageability. This is seen as central to psychological recovery. Also, important to the model is the distinction between distal and proximal goals.[32] Distal goals tend to have high meaningfulness, even though the person may currently lack self-efficacy in attaining them in the near future. The proximal goals that feed into those distant prospects have a high level of manageability, although they may have a lesser level of perceived immediate meaningfulness. The presence of the distal goal tends to imbue the proximal ones with greater meaning and commitment. The distinction often enables clinicians to avoid disputes over distal goals that the clinicians believe are impractical. Experience with successive proximal goals will show both consumers and clinicians whether the distal goal really does need modification. Consistent with these considerations, and with the emphasis on hope and a meaningful future relevant to psychological recovery, the CGT includes specific steps in which clinicians and consumers collaboratively develop and document (i) a personal recovery vision; and (ii) measurable 3 month goals to work towards this vision. These goals are then achieved by way of more specific tasks, usually set as homework tasks that comprise the fourth component of CRM, now described.

1.2.3 Collaborative task assignment and monitoring

Between-session task setting or homework is essential to this component, and integrates with the goals and vision of personal recovery. Although homework assignments have been used effectively within psychological treatments for a wide range of problems for some time, only recently has their role been explicitly summarized and described within interventions for schizophrenia.[33] This development provides great promise, given that generalization from psychosocial rehabilitation settings to the natural environment has provided a significant challenge in the past. By definition, homework provides the opportunity to generalize skills learned to naturalistic settings. The CRM includes three major stages for systematic homework administration: review, design and assignment, along with a range of strategies for identifying and overcoming obstacles to successful implementation.

2. EVALUATING THE EFFECTIVENESS OF CRM

The impact of CRM on the recovery of adults with chronic and recurring mental disorders is currently being evaluated by way of a multisite study in four government and five non-government organizations within NSW, Queensland and Victoria. This study constitutes one of three major research streams of the Australian Integrated Mental Health Initiative (AIMHI). Research sites have been randomly assigned to an immediate or 1 year delayed training condition. The collaborative recovery training programme is a six-module training programme based on the learning objectives outlined in Table 1.[34] Training is of 2 days duration with two 1 day booster sessions at 6 and 12 months after the initial training. Training is predominantly for clinical staff, although consumer advocates are encouraged to attend. As of December 2004, over 124 staff working with individuals who have chronic and recurring mental disorders (predominantly schizophrenia) and 189 consumers agreed to participate. Inclusion criteria for consumer participants are a diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder of at least 6 months duration and high support needs, with six or more needs identified using the CANSAS.[25] Individuals with dementia, severe mental retardation or brain injury were excluded. Comorbid substance misuse or personality disorders were not excluded. Following baseline, data collection is at 3 monthly intervals, consistent with national routine data collection. Measures include the Health of the Nation Outcome Scales (HoNOS), Life Skills Profile (16-item) and Kessler-10, supplemented with the Recovery Assessment Scale.[35] Both conditions have a 1 year follow-up intervention. Preliminary theoretical and immediate training outcomes suggest (i) that recovery is likely to be a measurable staged process; (ii) case managers frequently use homework with the target consumers but not very systematically without training; and (iii) collaborative recovery training leads to immediate improvements in staff knowledge and attitudes regarding recovery for consumers. Articles describing these initial findings are currently submitted and are under review.

Although formal evaluation is still pending, it is anticipated that the benefits of such an approach is the flexibility that it allows across services with highly variable resourcing and diverse structures (e.g. intensive vs less intensive case management approaches). The training has occurred in community mental health teams, rehabilitation services and supported housing contexts. Understanding the impact of the CRM requires systematic measurement of fidelity. However, the systematic measurement of psychiatric rehabilitation models has historically been a major area of neglect.[36] Given the lack of good quality measures, we chose the Dartmouth Assertive Community Treatment Scale (DACTS)[37] to provide some reference point across settings. Although the DACTS was designed to discriminate more intensive case management services, it has also been suggested that it ‘may be useful for delineating a typology of case management services in general’ (p. 79).[36] Additional fidelity indicators have been included for our recovery-specific training implementation. Implementation problems have varied to some extent dependent on the service and setting, but the most universal concern has been staff complaints about the lack of time they have to work with consumers who have less acute and more long-term needs. Working collaboratively with consumers and actively involving them in the treatment decision-making process takes time. The protocols expect an average of one contact every 2 weeks and some staff have found it difficult to provide this level of consistency with even one consumer. Workers in non-government organizations have become primary mental health supports by default when the public sector does not have the resources. However, for some, taking a more systematic and active approach in their work with consumers is new. We anticipate a future publication that elaborates upon the fidelity and implementation issues related to the project.

3. CONCLUSION

Achievement of a recovery orientation for mental health services requires training and development of attitudes and skills of the workforce. The CRM and its associated training programme were developed based on the existing evidence base, the identification of key skills and recognition of the importance of the subjective experience of recovery by consumers. The effectiveness of CRM to assist people with chronic and recurring mental disorders is currently being evaluated within several government and non-government agencies in Eastern Australia.

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