

The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: a qualitative investigation.

Abstract

Background: Recovery-oriented care has become guiding principle for mental health policies and practice in the UK and elsewhere. However, a pre-existing culture of risk management practice may impact upon the provision of recovery-oriented mental health services.

Aims: To explore how risk management practice impacts upon the implementation of recovery-oriented care within community mental health services.

Method: Semi-structured interviews using vignettes were conducted with 8 mental health worker and service user dyads. Grounded theory techniques were used to develop explanatory themes.

Results: Four themes arose: 1) recovery and positive risk taking; 2) competing frameworks of practice; 3) a hybrid of risk and recovery; 4) real-life recovery in the context of risk.

Discussion: In abstract responses to the vignettes, mental health workers described how they would use a positive risk taking approach in support of recovery. In practice, this was restricted by a risk-averse culture embedded within services. Mental health workers set conditions with which service users complied to gain some responsibility for recovery.

Conclusion: A lack of strategic guidance at policy level and lack of support and guidance at practice level may result in resistance to implementing ROC in the context of RMP. Recommendations are made for policy, training and future research.

Declaration of interest: None.

Key words: Recovery-oriented care; risk management practice, qualitative research.

Background

Recovery and mental health

Recovering from a mental illness has historically focused on the alleviation of symptoms through medication (Happell, 2008; Mountain & Shah, 2008). A more individualised concept of recovery has emerged which has been defined by people with lived experiences of mental health conditions as ‘living a satisfying, hopeful and contributing life’ in the best possible way despite their mental illness (Anthony, 1993:17). Individual recovery as a concept originated in the US from three ideological sources: the self-help movement (Mental Health Commission, 2001); mental health service user movement, e.g. ‘The Wellness Recovery Action Plan’ (WRAP) (Copeland, 2002); and psychiatric rehabilitation (Deegan, 1988). Recovery has often been researched through the collection of individual narrative. For example, in the UK the Scottish Recovery Network (SRN) and Rethink, a leading UK mental health charity, published reports which aimed to draw accounts from people’s experiences of mental illness in relation to their recovery (Brown & Kandirikirira, 2007; Rethink, 2010). There are a number of reoccurring themes derived from this literature describing individual recovery, including: hope (Ahern & Fisher, 2001); empowerment (Nelson et al., 2001); personal responsibility (Rethink, 2010); sense of identity (Repper & Perkins, 2003); social inclusion (Jacobson & Greenley, 2001).

Recovery-oriented care

On a policy level, recovery-oriented care – an approach that has been introduced into mental health services in order to explicitly support service users’ recovery journeys – has become an organising principle underlying mental health services in New Zealand (Mental Health commission, 1998), the US (Department of Health and Human Services, 2003) and Australia

(Australian Government, 2003). In order to support recovery, staff are encouraged to use ‘pro-recovery working’ practices in their day to day practice with services users including, for example, personal recovery plans (e.g. WRAP) , and shared decision-making (Shepherd et al., 2014). ROC can also be promoted through positive-risk taking, whereby service users are encouraged to take risks enabling them to move forward in recovery (Morgan, 2007).

In the UK, recovery-oriented care is supported by various Department of Health policies that promote self-management of long terms conditions and patient ‘choice’ (DH, 2001; 2006; 2008a). In 2007, the Department of Health published a ‘commissioning framework for health and well-being’ which stressed the importance of mental health services providing direct support to help people integrate into their communities (DH, 2007). Policies suggests that there are many factors that can help people to recover from mental ill health and have good quality of life: stronger social relationships, a greater sense of purpose, and improved chances in education, better employment rates and a suitable place to live (DH, 2011).

It has been noted in the American recovery literature, that recovery-oriented care cannot simply be ‘added-on’ to existing services, supports or systems and that the focus of transformation should be on changing and realigning current policies, procedures and practices (Davidson et al., 2007). It has been suggested that to design integrated systems of care, a collaborative consensus building process should be employed which are sensitive to barriers to change such as differing philosophies, regulatory processes, clinical traditions and policies and resistance to change (Barreira et al., 2000).

Risk management in mental health services

In the UK, the assessment and management of risk is a key component in the delivery of mental health services. Concerns have been expressed that the formalisation of risk management has resulted in service users becoming increasingly defined in terms of the risk they present ‘rather than in terms of their needs and rights’ (Langan and Lindow, 2004: 2). A number of policies have encouraged a move away from this traditional conceptualisation of risk by assessing services users’ social, family and welfare circumstances (DH, 1999); balancing care needs against risk needs (DH, 2007); involving service users in risk management through effective decision making and communication (DH, 2008b). This attempt to change risk management approaches is grounded in empirical evidence which, for example, suggests that addressing everyday risk concerns that are salient to service users reduces social isolation (Kalinieka & Shawe-Taylor, 2008). Roberts and Boardman (2014) have suggested that these more recent modifications in RMP may be central to developing ROC. There are, however, concerns about implementing ROC within a context of risk management practice. For example, Davidson and colleagues (2006, p642) invite the question, from the mental health professional’s perspective, “If recovery is the persons’ responsibility, then how come I get the blame when things go wrong?”

Risk and Recovery

There is a lack of research that explicitly explores the relationship between risk and recovery in the context of mental health services. In a focus group study exploring attitudes towards the social inclusion agenda, mental health workers reported an over-emphasis on managing risk that regularly acted as a barrier to the promotion of service users’ social inclusion (Bertram & Stickely, 2005). In an in-depth interview study exploring attitudes towards implementing direct payments (Spandler & Vick, 2005), care coordinators reported finding it difficult to

involve clients in their care when there was ‘an over-whelming focus on risk’ in their service (Spandler & Vick, 2005: 152). Marwaha & Johnson (2005) conducted semi-structured interviews with people who had a diagnosis of schizophrenia and bi-polar disorder in order to explore their views and experiences of employment. Service users were concerned about relapsing due to the increased stress and anxiety of returning to work whilst also fearing discrimination by colleagues (Marwaha & Johnson, 2005).

Aims

This paper reports a qualitative study that aims to address the lack of literature explicitly investigating the relationship between risk and recovery in mental health services by:

- 1) Exploring mental health workers’ and service users’ understandings of recovery-oriented care in the context of risk management practice;
- 2) Identifying how risk management practice impacts upon the implementation of recovery-oriented care.

Method

Study design

This study carried out qualitative in-depth interviews with mental health workers and service users in order to explore the relationship between risk management practice and recovery-oriented care.

Setting

The study took place in five community mental health teams across three boroughs in a London Mental Health Trust (governmental service provider).

Sample

8 mental health worker and service user dyads were recruited using a purposive sampling strategy to select ‘information-rich cases for in-depth study,’ (Patton, 1990:182). Mental health workers were first identified; they then identified a service user with whom they worked. Characteristics of the sample are given in tables 1 and 2 below. This information was collected through self-report information sheets filled in by participants prior to interviews.

[Insert table 1 and 2 here]

Data collection

Mental health workers and service users were interviewed separately. Each participant was presented with 5 vignettes sequentially. Vignettes illustrated situations where risk management practice might impact upon service users’ recovery in the community and were developed through focus groups with community-based mental health workers and service users. Vignette scenarios were identified and validated through comparison with existing empirical literature. Feedback focus groups were conducted to further validate and amend the vignettes (see Holley, 2014 for the vignette development process). An example of a vignette is provided in figure xx.

After presenting each vignette, participants were asked a series of questions such as ‘what do you think will happen next in this scenario?’ and ‘what do you think the mental health worker should do?’ Participants were also asked open-ended questions about whether the vignettes related to their personal experiences and if so, to describe what happened. All interviews were digitally recorded and transcribed verbatim.

[Insert figure 1 here]

Data analysis

Data analysis took part in three phases. An ‘open coding’ approach was used in the first phase to carry out line-by-line analysis of transcripts to generate as many potential categories as possible (Glaser & Strauss, 1967). Through a process of constant comparison of emerging categories (Green & Thorogood, 2004) eight overarching categories were identified. In the second phase, four descriptive themes were produced that cut across categories to illustrate ways in which participants articulated the relationship between risk and recovery.

In the final phase, the matrix query function within NVivo qualitative analysis software (QSRNVivo, 2008) was used to explore similarities and differences in mental health workers’ and service users’ accounts, as captured in the four descriptive themes. This process of considering discourse of recovery and risk from contrasting perspectives enabled us to develop four explanatory themes, each with a number of sub-themes. The first author undertook the analytical work with the data and refined emerging categories and themes through discussion with co-authors. The process of thematic development is illustrated in table 3 below:

[Insert table 3 here]

Results

The four explanatory themes are presented below with verbatim quotes from the data.

Participants are identified as either a mental health worker (MHW) or a service user (SU) followed by a numerical identifier.

1. Recovery-oriented care and positive risk taking.

This theme concerned mental health workers' abstract responses to the vignettes (what they would do hypothetically), illustrating how mental health workers said they would try to encourage service users to take risks in order to increase their responsibility for, and control over, recovery. Involving service users in risk decisions could be part of aspirational responses. For example, mental health workers explained how it was important to openly communicate risk to service users whilst trying to encourage them to identify strengths and acknowledge important risk concerns:

‘There are two ways of looking at it, either she makes a success out of it. Um, she um, motivated, inspired to be a success or the alternative is she goes the other way and starts using drugs again, gets into debts...’ (MHW3)

Mental health workers also stressed how their role was to support and enable service users to make decisions independently rather than make decisions on their behalf:

‘[...] if it is her wish to look after her finances then actually she is entitled and that needs to be explored very slowly with her [...] You can give her advice whether it’s a good decision or a bad decision but it’s her decision to take control of it.’ (MHW5)

2. Competing frameworks of practice.

When referring to real life situations (rather than our abstract vignettes), our analysis suggested that mental health workers could experience ROC and RMP as competing frameworks of practice, therefore elements of their role were in conflict. Mental health worker participants described how it could be problematic to encourage service users to move forward in their recovery whilst addressing risk:

Of course it can get difficult if the service user says no, “I want, I want to do it my way now,” Um, and then you have to have a very different conversation and you need to say that we feel collectively as a team that at this stage it’s still a risk. (MHW2)

Some mental health worker participants described how they experienced peer pressure to conform to their team’s risk-averse culture of practice and felt disempowered in encouraging

service users to take positive risks towards recovery. Decisions that involved risk were therefore the whole team's responsibility and not the individual mental health worker's:

'it's not just me, it's the team [...] she's going to be known to housing support workers, there are going to be other professionals involved. I wouldn't take the responsibility I would discuss it within the team.' (MHW6)

One mental health worker reported that where more traditional risk-averse practices were embedded within a team their ability to implement ROC was restricted:

'I have been accused I suppose, that's a strong word, but I tend to minimise risk. So you have to find a middle ground and I'll take all of that on board and there may be times when I think that's, I would be prepared to take the risk but I've been told by the team, "No, this, this isn't right."' (MHW2)

Mental health workers often described a sense of frustration, or powerlessness, when trying to encourage service users to move forward in recovery whilst also needing to address RMP issues:

'It never is very straight forward and it can be very frustrating because we do look at what the person should have just like you and I should have but yeah, there has to be that balance.' (MHW7)

The powerlessness experienced by mental health workers was also experienced by service users and as such might be described as mutual. Some service users were reluctant to take on responsibilities held by their mental health worker for fear of not being able to manage independently.

'You know holding you, putting you, wrapping you up in cotton wool yeah. And then all of a sudden that sort of goes away and then they're left to defend on their own. The problem is when you do show people that you are trying to attempt to do something then they think you are trying to be independent as well and they try and make you independent by not giving you the help.' (SU2)

3. A hybrid of risk and recovery

Our analysis suggested that the responsibility felt by mental health workers for assessing service users' mental capacity and managing risk of relapse contaminated the way ROC was enacted in their interactions; that ROC was 'hybridised' with RMP.

One service user participant described how they felt that, sometimes, mental health workers attempts to support service users in recovery could be undermined by them also not wanting to disclose risk issues to service users:

'She used to write things, like talk to me real nicely. But on the notes you would write things and I would be thinking "what the heck is wrong with you woman?" I need someone who is mutual and who is straight with me you know?' (SU1)

There was a sense that the aspirational account of ROC offered by mental health workers in relation to the vignettes was contaminated by their need to manage risk in practice. In the interviews, both mental health workers and service users tended to over-prioritise the alleviation of service users' symptoms in order to help service users' move forward in recovery:

'Just before she's discharged from hospital she's already talking about coming off of the depo. I'm not saying she doesn't have side effects but she just can't see why she needs to take it, she wants to do loads of courses but she can't kind of see why it's important to be well... and therefore she can't see how she behaves as a consequence as she becomes unwell.' (MHW1)

In turn this contaminated discourse of ROC seemed to lower participants' expectations of recovery. For example, a focus on medication compliance and reducing symptoms could contaminate service users' understandings of recovery:

'But there's always a bit of a worry that you might be, well, um, but I think um, I think if I keep taking my medication on a low dose I think, think um, it should be alright.' (SU5)

Service user participants expressed the need to allow mental health workers to retain some responsibility for recovery in order to avoid relapsing:

‘I’d just come off my medication and I should of seen my psychiatrist a long time ago. But it was put off by another two weeks. I believe that someone in such a situation needs to be supported more regularly then say like every once or two weeks or say like once a month.’ (SU8)

Additionally, on several occasions in the interviews, both in response to vignettes and in describing their own experiences, service users described how medication was the only option that could prevent them from being re-hospitalised:

‘There’s only one option [...] hospital. You know, he’s 34. He’s a grown man. Take your medication. Don’t mess people about it’s there for a reason.’ (SU6)

‘I’ve been off it 3 times and all of those 3 times, not including this time now, I’ve become, you know, something’s happened and I’ve become unwell.’ (SU8)

4. Real-life recovery-oriented care in the context of risk management practice

Interview data suggested that, in real life situations, mental health workers retained and took responsibility for reducing and managing service users’ exposure to risk. This constrained the extent to which service users were able to take on responsibility for recovery.

Mental health worker participants described how they had to set conditions and make decisions for service users’ recovery by drawing upon their professional knowledge and expertise for managing risk:

‘You need to have a real honest conversation and say that “I just don’t feel that you’re going to be able to manage at the moment, let’s talk about it again in six months’ time, this is what you want, this is what I want but we also need to ensure that when you do move you don’t come back because that would be awful to then feel like you’re going backwards.’ (MHW3)

Conditional offers set by mental health workers could determine the pace of recovery, resulting in service users feeling held back:

‘If she just leaves it to the key worker it’s obvious she’s just going to keep her waiting and tell the people on the housing register that she’s incapable of coping on her own.’ (SU1)

While service users’ did not seem to share mental health workers’ risk concerns they nevertheless did seem compelled at times to collude with the conditions mental health workers’ set:

‘He will have to go back on an appointee-ship but for how long I don’t know. He’s got to prove himself again because he’s let them down.’ (SU6)

‘They describe you by your notes and they start treating you by your notes and you have to pull up and tell them that no, it’s about your personal development and you have to prove yourself.’ (SU1)

Discussion

In the interviews, some mental health workers described how, in principle, they would enable service users’ to make their own decisions about recovery. In this hypothetical talk about recovery issues, risk could seem to be neglected. It has been acknowledged that the paradigms in which ROC and RMP are situated are seemingly opposite to one another (Roychowdhury, 2011). This is emphasised particularly in ROC policies, which insist traditional RMP procedures are restrictive for ROC (DH, 2008b). Our analysis suggests that idealistic thinking about recovery might inhibit proper consideration of how risk might be managed in the context of recovery orientated care.

In the context of this lack of explicit thinking about risk and recovery our analyses suggest that mental health workers’ aspirations to implement ROC could, in the real world, be contaminated by the responsibility they feel for managing and reducing service users’ exposure to risk. This supports research findings which found that mental health workers

experience role-conflict where they are concerned with being accountable if anything should go wrong while still feeling that they should be working in a recovery-oriented way (Samele et al., 2007; Sawyer, 2008). In our interviews, some mental health workers described how it was important for service users to make decisions independently about their recovery whilst, simultaneously, expressing concerns about the adverse outcomes that could result from handing over responsibility to service users. This reflects literature that has introduced the concept of powerlessness where mental health workers did not want to exert power over their clients and as a result ‘sometimes struggled in shaping practices of client participation’ (Broer et al., 2014: 208).

An over-prioritisation of symptom alleviation is thought to compromise the overall ethos behind a core concept of individual recovery, which is about maximising service users’ potential despite and alongside their mental illness (NIMHE, 2005). Some mental health worker participants retreated to a safer and more conservative way of supporting individual recovery which, in practice, resembled an illness management model of recovery (Gingerich & Mueser, 2005). Our analysis suggests that this approach – which focuses on symptom control and long term monitoring of an illness whilst also pursuing personal goals outside of a mental illness (Mueser et al., 2002) – might have been experienced as more realisable when risk issues were present. Although the alleviation of symptoms through medication is recognised as an important component of recovery (Happell, 2008), over emphasis can detract from efforts to address other elements that make up the ‘whole’ person (Andresen & Oades, 2003). As such we observed how support for service users’ potential to ‘recover in’ their mental illness could be contaminated by the apparent prioritisation of ‘recover[y] from’ a mental illness (Whitwell, 1999).

Whilst working out how to implement ROC in the context of RMP, mental health workers emphasised their professional accountability, suggesting that they would not be held

solely accountable for the decisions made for service users' recovery. Making team decisions in order to share the blame of adverse events may, however, restrict the implementation of ROC and positive risk taking (Roberston & Collinson, 2011).

In situations where service users are considered by mental health workers to be at risk of harming themselves or others, their personal preferences for care can be overridden by the risk considerations of mental health workers (Samele et al., 2007). In our interviews, service users felt the need to gain mental health workers' trust by proving they could take on responsibility for recovery.

The extent to which service users gained responsibility for recovery was not an indicator of their independence but an indicator of whether they could demonstrate personal responsibility by following conditions set by mental health workers. Data in this study suggests that service users understood 'shared decision making' more as an act of collusion with the conditions set by mental health workers than as an active role in the decision making process. This is in marked contrast to shared decision making as described in the literature, where the centre of gravity should shift towards a collaborating partnership between the service user and mental health worker (Slade, 2009). In the discourse of recovery-orientated care in the context of risk management practice that we elicited here, service users gained responsibility for managing their own risks and exercised control over their own recovery only when colluding with conditions set by mental health workers.

Strengths and limitations

The use of vignettes to elicit data from service users and mental health workers enabled in-depth critical thinking about discourses of recovery and risk management in the context of mental health service provision, helping to address an important knowledge gap. Future

research should employ more deductive, designed to test the understandings of risk and recovery developed in this study in a range of service delivery contexts and with other populations.

Conclusion

Our findings suggest that an apparent inability to implement ROC might be due to a lack of guidance on how to address RMP issues within ROC strategy. This may result in mental health workers being unsure of how to implement ROC while also needing to fulfil their traditional obligations to manage risk. RMP procedures could be made more explicit in ROC policy by being incorporated alongside positive risk management strategies to help mental health workers shape more realistic practices of service user participation. Apparent resistance to implementing ROC displayed by some mental health teams and individual workers may stem from this lack of explicit guidance at policy level, as well as a lack of support at practice level where mental health workers are embedded in a risk-averse organisational culture. Our findings suggests that only if a less risk-adverse culture emerged in NHS Mental Health Trusts could a ROC approach be implemented more explicitly that reflected understandings of recovery as articulated within the service user movement.

Our findings also suggest that it is something like an illness management model of recovery that emerges by default in order to take into account that in practice, mental health workers are responsible for managing and reducing risk and thus find it difficult to implement ROC. On a policy level, this default mode of recovery should be acknowledged, either as an actual organisational objective or as something to be addressed and challenged, where this is

not the individualised ROC that is ostensibly shaping the service. Only with this level of candor will the tensions between RMP and ROC be addressed.

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