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Service Providers' Experiences and Perspectives on Recovery-Oriented Mental Health System Reform

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Abstract

Objective—With the use of a qualitative approach, this study focuses on service providers' experiences and perspectives on recovery-oriented reform.

Methods—Nine focus groups were conducted with a sample of 68 service providers recruited from three Canadian sites.

Results—Three major themes were identified: 1) positive attitudes towards recovery-oriented reform; 2) skepticism towards recovery-oriented reform; and 3) challenges associated with implementing recovery-oriented practice. These challenges pertained to conceptual uncertainty and consistency around the meanings of recovery; application of recovery-oriented practice with certain populations and in certain contexts; bureaucratization of recovery-oriented tools; limited leadership support; and, societal stigma and social exclusion of persons with mental illnesses.

Conclusions and Implications for Practice—The findings point towards challenges that might arise as system planners move ahead in their efforts toward implementing recovery within the mental health system. In this regard, we offer several recommendations for the planning of organizational and educational practices that support the implementation of recovery-oriented practice.

Keywords

system transformation; recovery-oriented system; recovery-oriented care; recovery

Introduction

In the past decade, recovery has become a key concept influencing mental health policy, systems, and services around the world (Compagni, Adams, & Daniels, 2006; Piat & Sabetti, 2009). Little attention to date has been placed on providers' perspectives regarding the early stages of recovery-oriented reform and the challenges they experience in implementing recovery principles into their day-to-day practice. Such knowledge could help with the planning of education, research, and administrative practices to facilitate the

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transformation towards recovery-oriented care (Buckles et al., 2008). This is particularly important in countries such as Canada, where recovery is a key organizing concept for a proposed national mental health strategy (Mental Health Commission of Canada, 2009) and where organizational efforts towards implementing recovery-oriented practice are currently underway.

This study explored the experiences of consumers, service providers, and decision makers receiving, providing, and planning mental health services in Canada[1] on recovery-oriented practice and reform. Data collection methods included focus group interviews with service providers and individual interviews with consumers and decision makers. In this article, we report on the findings from the focus group interviews with service providers.[2] Our aim was to elicit providers' experiences and perspectives on recovery-oriented changes within their organizations and the barriers they faced in implementing recovery-oriented practice. We begin by providing a brief overview of the recovery concept and the principles of recovery-oriented care, followed by a review of the challenges in relation to implementing recovery-oriented practice.

The Recovery Concept and Recovery-Oriented Care

Recovery is defined by consumers as a transformational process associated with hope, engagement, self-determination and social connectedness (Ahern & Fisher, 2001; Frese & Davis, 1997; Ridgway, 2001). It is an ongoing, lifelong, and subjective process (Davidson et al., 2005; Davidson & Staynor, 1997; Smith, 2000; Spaniol, Wewiorski, Gagne, & Anthony, 2002; Young & Ensing, 1999) that leads to a more fulfilling, satisfying, and contributing life despite the presence of symptoms (Anthony, 1993; Deegan, 1988; 1996). These definitions have provided a conceptual foundation for developing the principles of "recovery-oriented" care.

Under the framework of recovery, the primary goal of mental health services is to support individuals in their journey towards overall health, well-being and social integration. This entails a shift in the way mental health services have traditionally been delivered and requires the development of new values, service goals, and practices. The focus of mental health services extends beyond symptom management to supporting individuals towards the attainment of housing, employment, education and citizenship. Moreover, relationships between service providers and consumers are manifested by openness, reciprocity, and collaboration (Shepherd, Boardman, & Slade, 2008). Institutional practices at the level of culture, commitment, and capacity to reflect the extent to which an organization is engaged in recovery-oriented care (Farkas, Ashcraft, & Anthony, 2008). For example, organizational hiring practices that include employing individuals with experience of receiving mental health services in different roles and levels of leadership within the organization can reflect recovery values.

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[2]Findings on consumer perspectives are reported in Piat et al. (2008; 2009) and findings on decision maker perspectives are reported in Piat et al. (2010).

Armstrong and Steffen (2009) developed a recovery fidelity scale that measures the extent to which institutional practices reflect principles of recovery. It includes 12 institutional practices that are categorized according to five recovery principles: “collaboration; participation and acceptance; self-determination and peer support; quality improvement; and development” (p. 167). Practices measured by the scale include: using satisfaction surveys semi-annually; implementing service improvement mechanisms that involve service users’ input; hiring persons in recovery to work in the agency; providing training on recovery to staff within 30 days of hire; employing peer supporters within the agency to serve as advocates.

System-wide initiatives have been developed internationally to facilitate the implementation of recovery-oriented care. For example, Connecticut’s statewide initiative is a leading example of the processes involved in re-orienting a mental health system towards recovery-oriented practice. This includes: developing a policy framework based on recovery values conceptualized using consumer perspectives; implementing recovery-oriented training, education, and consultation; making changes to organizational programs, practices, and structures to reflect recovery philosophy; and the evaluation of implementation efforts (Davidson et al. 2007). In the U.K., several policy-practice documents have been developed for mental health service professionals working at different levels of the system to help translate the principles of recovery into practice (Sainsbury Centre, 2009; Shepherd, Boardman, & Burns, 2010; Shepherd et al., 2008).

Challenges of Implementing Recovery-Oriented Care

While the idea of moving towards recovery-oriented reform is generally accepted by system planners and administrators, the actual implementation of recovery principles into organizational structures and practices continues to be of concern (McVanel-Viney, Younger, Doyle, & Kirkpatrick, 2006). Implementation obstacles encompass conceptual, philosophical, attitudinal, and practical matters. From a conceptual perspective, recovery is considered to be an ambiguous term and there are inconsistencies in how it is understood across stakeholder groups (Lal, 2010a; Piat et al. 2009). There are other concerns with regard to philosophical incongruence between recovery-oriented/consumer-survivor perspectives and the medical model wherein traditionally the service provider is the expert and disease, diagnoses, and disability have been the focus (Davidson & Roe, 2007). Recovery has been referred to as “esoteric nonsense,” “hard to grasp” and “lacking an evidence base” (O’Hagan, 2004, p. 1). Providers may be continuing to support institutional practices that are inconsistent with recovery principles (Buckles et al., 2008). From a practical standpoint, some service providers are uncertain regarding what concrete changes are implied by recovery-oriented reform, if any to their day-to-day work, whereas others claim to already be implementing recovery-oriented practice (Davidson, O’Connell, Tondora, Styron, & Kangas, 2006; Dickerson, 2006). It is important to note, however, that most of these challenges have largely been based upon anecdotal reports rather than systematic inquiry. The extent to which service providers are embracing early efforts towards recovery-oriented reform as well as the implementation challenges they experience remains unclear.

Methods

Setting

The study was conducted at three sites across two provinces in Canada, Quebec and Ontario: 1) the Douglas Mental Health University Institute; 2) the Canadian Mental Health Association (CMHA) and the Self-Help Alliance, a consortium of user-run services and 3) PECH (Programme d'Encadrement Clinique en Hebergement), a community mental health organization providing housing and crisis services. At the time of the study, all three sites were in the early stages of implementing recovery-oriented practice into their organizations. The Douglas Mental Health University Institute identified recovery as the priority in its strategic plan (Douglas Hospital, 2006), and also created an official recovery program within its clinical services. The CMHA adopted a recovery "model" for its case management services (Townsend, 2005) and recovery formed the guiding principles for the Self-Help Alliance. PECH described their services as a strengths-based, alternative model, which integrates recovery values and principles into practice (PECH, 2007).

The ethics review boards of each site approved the research. An Advisory Committee oversaw the research and met three times during the study to validate the research process. Participation in the study was voluntary. All participants signed and received a copy of the consent form. In reporting the findings, no identifying information has been used.

Data Collection Procedures

Nine group interviews were conducted with service providers using a semi-structured interview guide developed in consultation with the research team and Advisory Committee. Participants were asked a series of open-ended questions such as: how do you define recovery; how do the services provided by your team reflect recovery-oriented practice; and, how is recovery-oriented practice part of your day to day work? A short sociodemographic questionnaire was administered at the start of each group. Questions included job title, professional affiliation, years of experience in mental health, and current position. Two to three research team members attended each group, taking turns moderating while the other(s) took notes. Seating was pre-arranged, and nameplates were provided, so each participant could be identified in the notes taken. Each focus group interview lasted between 90 and 120 minutes, was tape recorded, and transcribed verbatim.

Sample

The research team first compiled a list of all service providers from each site. These included staff working on multi-disciplinary teams (social workers, psychologists, occupational therapists and other health professionals), who represented various levels of service delivery (e.g., front line, clinical supervisors, team leaders, program managers), and worked in diverse settings within the sites (e.g., inpatient units and outpatient clinics). Individuals were randomly selected from the compiled list until groups of 8 to 10 participants were attained. A total of 113 people were contacted from which forty-three declined to participate due to scheduling conflicts, or failure to return the call. Two were absent from their interviews. A total of 68 service providers participated.

All of the participants were mental health professionals involved in providing direct services to persons with serious mental illness. The mean age of the 68 participants was 44 (*SD* 11.4) and 77% were female. Participants had worked an average of six years in their present job, and fourteen and a half years in mental health. Their educational backgrounds included university-level studies in social work (30%), psychology (15%), nursing (12%), education (9%), and administration (7%).

Data Analysis

Data analysis was a multi-staged process that involved: 1) research team members listening to all nine audio-tapes, checking them against the transcriptions, 2) team agreement on two broad codes to systematically apply to the entire data set: reacting and responding to recovery-oriented reform, and implementing recovery-oriented practice, 3) analysis of the extracted broadly coded data using an inductive, open coding process, and 4) identification of twelve secondary codes which were subsequently regrouped into three themes. Table 1 provides an overview of the codes and themes generated through this analytical process.

Specific efforts were taken to ensure the trustworthiness of the study. Data analysis was a shared process involving constant team discussion. Findings were presented to participants for feedback. A detailed audit trail including raw data (transcriptions), data reduction and analysis materials (codebooks, memos, draft findings) was kept throughout the study. N-Vivo 8 was used to navigate the transcripts, create codes and categories, and identify quotes.

Findings

Findings presented in Table 1 revealed three major themes: expressing positive attitudes toward recovery-oriented reform; expressing skepticism toward recovery-oriented reform; experiencing challenges with the implementation of recovery-oriented practice.

Expressing Positive Attitudes toward Recovery-Oriented Reform

Some participants perceived that the shift towards recovery-oriented practice represented a radical change in the mental health care system and a better way of delivering services. These participants expressed that recovery-oriented reform brings attention to the environment and social determinants of health rather than simply focusing on changes within the individual. They perceived that the concept of recovery provides a unifying foundation upon which different stakeholders in the community can work together to deliver a continuum of services that is meaningful to consumers. They emphasized that recovery-oriented reform entailed shifts within the power relationship between service providers and consumers from being paternalistic/prescriptive to egalitarian/collaborative.

> It’s another way of working, another way of working that involves a mourning process for staff. We need to mourn the loss of power we’ve taken on as specialists, as those who claim to know what’s best for that person…if we really apply (recovery) it’s something that’s revolutionary. It’s something that completely changes the helper-helpee relationship. [FG 7]

These participants also perceived value in making use of the term recovery in their daily interactions with consumers and with staff.

> I use the term all the time…It's in our mission statement. It's in our values. It's in our objectives…people might, you know, not agree with my point of view but I think that a word, there is a lot to be said for a word…I think it gives a clear message if people use the word and like, they use it and it's in their gut. I think then that you can't help but eventually the practice comes with it. [FG 3]

Moreover, participants were of the opinion that some service providers tend to minimize the radical nature of, and overestimate the extent to which they engage in, recovery-oriented practice.

Expressing Skepticism toward Recovery-Oriented Reform

In contrast, other participants argued that recovery-oriented reforms within their organizational contexts did not contribute anything new to their practice. They emphasized that that they were already implementing recovery long before it became a politicized concept. They characterized the term recovery as a "buzz word" or "fad" in mental health discourse, and a re-invention of what already existed.

> At times I have the impression that we just change our terms… that we just add words to something that already exists…So at times I find it not really so great… but it's just like a way of reinventing with new words. [FG 8]

> It's a buzz word, it's in fashion…even though it's really nowadays in fashion, it's always been at the heart of the alternative mental health movement in Quebec. [FG 7]

Some participants also questioned the utility of using the term recovery in their interactions with consumers because of: its association with "cure"; its tendency to reinforce the illness or convey to clients that they need to "change something that is wrong with them"; its association with jargon and/or "philosophical discourse." Additionally, providers questioned whether recovery-oriented reforms within their organizations will have an ultimate impact on client outcomes.

Experiencing Challenges with Implementing Recovery-Oriented Practice

Participants described numerous challenges related to implementing recovery-oriented practice including: conceptual uncertainty and inconsistency regarding the meaning of recovery; application of recovery-oriented practice in certain population and work contexts; bureaucratization of recovery-oriented tools; limited leadership; and, dealing with stigma and social exclusion of persons with mental illness.

Conceptual Uncertainty and Inconsistency Regarding the Meaning of Recovery

Participants were uncertain regarding the meaning of recovery and wrestled with its various definitions particularly in relation to other terms they were familiar with.

> What's recovery? I still have trouble to really understand it. It's a process, we know that it's this idea of a process, and I want to say, we've seen all sorts of definitions.

> I've seen many in my time…what's the difference between empowerment and recovery? [FG 7]

Implementation of Recovery-Oriented Practice in Specific Contexts

Some participants spoke about challenges in applying recovery with certain populations and in particular practice settings, such as: short term/crisis interventions, inpatient care, and housing.

> It's just because of the nature of the service… sort of brief encounters with us; and it's very focused on the current crisis that's going on; so, recovery tends to be, I think, a longer term concept…there's certainly interventions for sure where it would come into play, but for the most part… it's not the conversations that we'd be having. [FG 9]

> How can you talk to them about recovery, when you know that there's nothing to eat in your fridge or you live on the streets, or if you're just getting out of hospital - it's all of that. [FG 9]

Bureaucratization of Recovery-Oriented Tools

Participants expressed frustration with regard to the bureaucratic burdens of being mandated to use recovery-oriented tools in their practice. They thought that the mandating of recovery-oriented tools placed too much attention on outcomes as opposed to process, or conducive to the implementation of recovery-oriented practice.

> I think everybody really wants to move forward with recovery but everyone's also struggling with this tool. I would be doing whatever I'm doing with the one person I support right now; except, now it's written on paper…and now I have to write it all out, and I have to get it approved…and now it's gonna take like 6 weeks with the paperwork being approved and going through the process. To do something that I would've done anyway…three signatures on one process. [FG 4]

Limited Leadership Supports

Some participants described a "top-down" approach in the planning and implementation of recovery practices in their milieu and expressed disappointment for not being consulted by organizational leaders. They felt unsupported in terms of the changes they were expected to make and experienced limited opportunity to reflect about the contextual application of recovery principles in their work settings. They also perceived that organizational leaders were not genuine in their approach to implementing recovery-oriented practice nor knowledgeable regarding its principles.

> The thing that I have the most frustration with is that I feel like the hospital is trying to sell something to us the workers and then the clients, trying to sell a product that they really do not believe in. And this product is recovery. [FG 2]

Dealing with Stigma and Social Exclusion

Some participants identified stigma and social exclusion as challenges they encountered in their efforts to support recovery. They expressed frustration in the loss of time and energy

when having to interact with individuals from other service sectors, such as justice, housing, and employment who are poorly informed about or have negative attitudes towards persons with mental illness. Participants also identified the poor socioeconomic status of many persons living with mental illness as a challenge to implementing recovery-oriented practice as helping individuals meet basic day to day survival needs takes precedence.

Discussion

Much attention has been placed on conceptualizing recovery from the perspectives of consumers. Our study shifts attention from this critical first step of understanding, towards implementation of recovery-oriented changes in the system. Specifically, our findings contribute to the literature in terms of the types of challenges that might exist in the promotion and implementation of recovery-oriented practice in Canada and potentially elsewhere in the world.

Service providers expressed a range of perspectives on recovery-oriented reform and practice, some of which have been reported anecdotally in the literature such as negative attitudes towards recovery-oriented reform (e.g., Davidson et al. 2006). The skepticism that providers expressed could be attributed to fears of losing professional power or increasing workload (Davidson et al. 2006), and at least in part related to: the quality of leadership and commitment providers experienced within their organizations; the extent to which they were engaged in the planning of recovery-oriented reforms and were supported in the process of reflection on the meanings of such reforms in their settings.

Negative attitudes towards recovery-oriented reform have also been attributed to a lack of knowledge on evidence in two areas: 1) longitudinal studies demonstrating the possibility of recovery for individuals with serious mental illness, and 2) effectiveness of recovery-oriented services on consumer outcomes (Davidson et al., 2006). Lack of knowledge on the part of service providers regarding the evidence base on recovery-oriented services is conceivable considering that it is only in the past two decades that recovery-oriented services have begun to be rigorously studied. For example, interventions that have been developed and facilitated by individuals who have experienced mental illness, and which are based on recovery principles such as self-determination and hope, such as WRAP (Wellness Recovery Action Plan), are now being tested and demonstrating positive outcomes in terms of quality of life, symptom reduction, and hope (Cook et al., 2011). As the evidence base for recovery-oriented services increase, the systematic review and translation of these findings to service providers will become imperative to promote attitudinal changes regarding recovery-oriented reforms. At the systems level of care, research is currently focused on the barriers and facilitators of recovery-oriented reform, the process of reform, and how to measure the extent to which systems are recovery-oriented, as opposed to evaluating outcomes of transformed systems of care.

Recent evidence suggests that formal training can improve providers' attitudes and knowledge on recovery prospects for individuals affected by mental illness and recovery-oriented practices (Crowe, Deane, Oades, Caputi, & Morland, 2006; Tsai, Salyers, & Lobb, 2010). Training programs that incorporate recovery principles and evidence-based practices,

such as the Collaborative Recovery Model, demonstrate effectiveness in improving knowledge and attitudes of service providers on recovery (Crowe et al. 2006). Thus, the type of training that service providers are exposed to (e.g., skills based or knowledge based), the amount of training, and its quality may be important factors to consider in the transformation towards recovery-oriented care.

Providers working in specific contexts and/or with certain populations (e.g., inpatient hospital settings, services for homeless populations, and crisis services) struggled with the implementation of recovery philosophy. This challenge of applying the recovery concept to certain population contexts and practice settings has also been raised in the literature (e.g., Lal, 2010a; Piat, Sabetti, & Bloom, 2010). The limited association of recovery with inpatient settings may be a reflection of the shift of attention towards community based services in mental health care reform, which risks blindsiding the issues and needs of crisis and inpatient care more generally (Lal, 2010b).

Recent attempts have been made to address the challenge of applying recovery-oriented practice within certain contexts. For example, in the U.S.A., a webinar entitled, “What recovery means in acute care” was recently hosted by the Recovery to Practice (RTP) national training initiative (Bennington-Davis, Bluebird, Stoneking, Swartz, & Davidson, 2010). In this webinar, the following topics were discussed: how to create a climate of recovery in the acute care setting; the integration of peer specialists in acute care settings; residential alternatives to crisis services; and psychiatric advance directives.

Our findings reveal that service providers struggled with the implementation of recovery principles in their day to day work due to: limited organizational leadership, institutional practices and policies, and training and support. These experiences tell a cautionary tale regarding the potential risk for the perpetuation of institutional bureaucracies as system planners begin to mandate recovery-oriented reform through specific policies and tools without adequate foresight.

Societal stigma and social exclusion of persons with mental illness was also an issue that service providers expressed concern over in their efforts to implement recovery-oriented practice. In the process of reforming mental health care, policy makers have recognized that stigma is a major barrier towards the process of recovery for individuals living with mental illness (e.g., New Freedom Commission on Mental Health, 2003). Thus, stigma has become the focus of several small and large-scale targeted population-based efforts to change attitudes, beliefs, and knowledge about mental illness. Although health care providers have been the target of many anti-stigma efforts, for example, the Mental Health Commission of Canada’s Opening Minds initiative, our study suggests the importance of targeting providers working in other sectors as well, such as justice, employment and housing.

Strengths and Limitations

The strengths of this study include the random sample selection, the diverse settings from which participants were recruited, as well as the variation in levels of authority that participants represented (e.g., front line, clinical supervisors, team leaders, program managers). We conducted several focus group interviews (n=9) and had a fairly large

number of respondents (n=68) comparative to the average number of focus groups and sample sizes found in health studies using focus group methodology (Carlsen & Glenton, 2011; Twohig & Putnam, 2002). Our findings are however nuanced by certain limitations. The findings represent an overview of providers' experiences and perspectives during the initial phases of recovery-oriented reform in Canada. The sample does not represent a generalized portrait of all Canadian mental health providers. Also, the dynamics inherent in focus group interviews do not always allow people to express their views fully and therefore, our findings may not represent the full range and depth of existing perspectives. Psychiatrists, primary care health workers, and individuals working outside of the mental health sector were not included in the study. Further research that captures the ongoing experiences and perspectives of a wider range of providers is needed.

Conclusion

While the aim of current mental health policies is to transform the mental health care system, there is concern as to whether these efforts will transgress political rhetoric and induce actual changes in the services delivered. To support the implementation of recovery principles into practice, we offer several recommendations based on the findings from this study. First, providers need to receive training that will enrich their understanding of recovery values and principles, and help them acquire new approaches and skills to practice. A core document that describes what recovery is and provides examples of how recovery can be translated into different service contexts could support training initiatives. Canada might consider a national approach to facilitate the translation of recovery-oriented mental health policy into practice. Second, decision makers and administrators need to consider whether institutional practices and policies are consistent with recovery philosophy; this includes the consideration of referral systems, assessment procedures, approaches to discharge (Sainsbury Centre, 2009) and treatment planning. Third, service providers need to be supported by leaders in the planning of institutional practices and training that can meaningfully improve the services and experiences of consumers. Fourth, no effort to reform the mental health care system will be successful without educating providers working in other sectors of public health and the community at large on recovery. Fifth, the contextual application of recovery-oriented reform needs to be given increased attention in policy and strategic planning. To support these planning efforts, research is needed on the application of recovery principles in specific mental health care settings, services, and population contexts. Finally, and perhaps most important, the active engagement of consumers in the process of transforming the mental health care system towards recovery-oriented care is necessary to ensure that reforms ultimately respond to their needs.

The findings from this study arrive at a critical juncture during mental health care reform in Canada. To ensure that the goals of the proposed national mental health strategy translate into practice, it will be important to consider the experiences and perspectives of different stakeholder groups throughout the stages of system reform. Our efforts represented in this paper are initial steps towards this objective and have implications for the development of effective training and procedures to support the shift towards system transformation.

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Table 1

Service Providers' Perceptions: Codes and Themes

Primary codes	Secondary codes	Themes
Reacting and responding to recovery-oriented reform	• Represents a radical change and better way of delivering services	1) Expressing positive attitudes towards recovery-oriented reform
	• Extends focus from individual to the environment	
	• Requires change in power relationships	
	• Provides a conceptual foundation to unite stake-holders	
	• A political fad/just another buzz word	2) Expressing skepticism towards recovery-oriented reform
	• Doesn't contribute anything new to practice	
	• Questioning the evidence base	
Implementing recovery-oriented practice	• Conceptual uncertainty and consistency regarding the meaning of recovery	3) Experiencing challenges with the implementation of recovery-oriented practice
	• Contextual application of recovery-oriented practice	
	• Bureaucratization of recovery-oriented tools	
	• Limited organizational supports and leadership	
	• Stigma and social exclusion of persons with mental illness	