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From Recovery Programs to Recovery-Oriented Practice? A Qualitative Study of Mental Health Professionals' Experiences When Facilitating a Recovery-Oriented Rehabilitation Program

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A B S T R A C T

Introduction: The recovery model has influenced mental health services and fostered new standards for best practice. However, knowledge about how mental health care professionals (HCPs) experience recovery-oriented programs is sparse.
Aim/Question: This paper explores HCPs' experiences when facilitating a recovery-oriented rehabilitation program. The research question is how do HCPs experience a change in their attitude and practice when applying recovery-oriented programs?
Methods: This paper draws on semi-structured in-depth qualitative interviews conducted with 16 HCPs experienced in facilitating a recovery-oriented rehabilitation program in either the USA or Denmark.
Results: Three themes emerged from the HCPs' reflections on changes in attitudes and practices: "Hopeful Attitude" captures a change in the HCPs' attitude toward a more positive view on the future for clients' living with mental illness; "A New Focus in the Dialogue With Clients" thematizes how the HCPs focus more on the individual's own goal for recovery rather than disease-induced goals in the dialog with clients; "A Person-Centered Role" comprises a shift in the professional role whereby the HCPs value the client's own ideas in addition to the professional's standards.
Conclusion: This study supports the theory of the recovery model by its empirical findings and indications that when facilitating a recovery-oriented program, HCPs experience recovery-oriented changes in their attitude toward life with mental illness, and it alters their professional practice toward a stronger focus on client's own goals during treatment. More studies are needed to further clarify how changes in HCPs' attitudes translate into changes in mental health practices.

Theories and models of recovery have influenced mental health services and fostered new standards for best practice. But how do mental health care professionals (HCPs) experience their professional practice when implementing recovery-oriented services? Do they, for instance, perceive a change in the way they act toward their clients? Do they notice that they perform differently in their job?

The values of the recovery model are: promoting hope, well-being, self-management and improving social inclusion so the individual in recovery feels more like being a part of their local community and surrounding world (Anthony, 1993; Davidson et al., 2007; Slade, 2009). However, very little empirical evidence exists on how HCPs experience their professional practice when implementing recovery-oriented services. Most literature on mental health care services documents how mental health care has been and still is dominated by the medical model. The medical model focuses on categorizing and solving problems that result from the illness and values preservation and restoration of mental health which is about maintaining status quo (Davidson & Roe, 2007; Slade, Amering, & Oades, 2008; Warner, 2009). The fundamental basis of recovery-oriented services is to support the person's recovery process no matter what the starting point is, by facilitating an active collaboration between the person with mental illness and the mental health care professional (Farkas, 2007). To sum up, recovery-oriented services should encourage client self-knowledge about the mental illness, teach strategies to cope with symptoms, support client efforts toward self-efficacy, and especially toward increasing social support. Within this model the recovery-oriented practitioner nurtures the client's hope and holds hope for the client when the client is without hope.

In 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA launched a plan to transform mental health care by emphasizing the principle of recovery (O'Connor & Delaney, 2007; Substance Abuse & Mental Health Services Administration (SAMHSA) (SAMHSA), 2006). In that transformation, a distinct

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strategy by SAMHSA was to promote recovery-oriented practice initiatives for professionals; one such efforts called the Recovery to Practice from 2010 has been an important part of this strategy (Delaney, 2012). The initiative was intended to support the expansion and integration of recovery-oriented care delivered by HCPs as well as to provide resources and training for HCPs. Action plans and strategies for mental health care to promote recovery-oriented practice have likewise been proposed by mental health authorities around the world and not only in the USA (Le et al., 2011).

In spite of those initiatives, literature about recovery-oriented changes in mental health care delivery is limited. A few of those studies have shown that professionals' attitude toward clients' recovery improved so that they perceived recovery from mental illness as possible after attending recovery-oriented training (Gudjonsson, Webster, & Green, 2010; Wilrycx, Croon, van den Broek, & van, 2012).

Other such studies have addressed how this new knowledge of and attitude toward recovery influenced the practice of the professionals. One study suggested that if the recovery training is provided jointly by both client and HCP, it is likely to be beneficial for the relationship between the client and the HCP (Salkeld, Wagstaff, & Tew, 2013). Another study found that recovery training gives the professionals new knowledge of what recovery is and leads to changes in care plans. By analyzing audit data from care plans, quantifiable changes in outcomes have been found such as change in care plan focus and change in who is responsible of action in the next step of the client's treatment (Gilburt, Slade, Bird, Oduola, & Craig, 2013). Finally, a study investigated how training of professionals in the elements of a recovery-oriented rehabilitation program has influenced their attitudes as evaluated by questionnaires. The authors also concluded that HCPs' training correlates with their higher client optimism and greater orientation toward the client's goals (Tsai, Salyers, & McGuire, 2011).

As promising as those findings are, there still appears to be a gap between the academic teaching of recovery-oriented care and the perceived ability and confidence by the professionals in delivering recovery-oriented practice. A questionnaire study of community mental health nurses' perspective of recovery-oriented care argues that such a gap exists and that there is little known about HCPs' experiences and perceptions of applying the recovery-oriented approaches (Gale & Marshall-Lucette, 2012). Altogether, the few studies in this area indicate that formal training in the recovery model influences the mental health care professionals' knowledge and attitude. However, there is little information of how professionals are influenced not just by their formal training in recovery but by their experiences of working with clients using the recovery model and how they then integrate this new philosophy of care in their daily practice.

In this study, the illness management and recovery (IMR) program was used as an example of a recovery-oriented program implemented into day-to-day practice, since it is an example of a well-defined recovery-based program. The IMR program was developed as an evidence-based curriculum program facilitated by professionals to promote recovery for people with severe mental illnesses (Mueser et al., 2006). The program consists of 11 modules that form a recovery-based curriculum, focused on for 6–12 months, with 1–2 sessions weekly.

The 11 IMR modules are: recovery strategies, practical facts about mental illness, the stress-vulnerability model, building social support, using medication effectively, drug and alcohol use, reducing relapses, healthy lifestyle, coping with stress, coping with problems and symptoms, and getting your needs met in the mental health system.

Previous research of the IMR program has focused on either clients' outcome measures or on the organizational implementation of the program (McGuire et al., 2014), whereas this article focuses on the mental health care professionals' experience with practicing IMR within their daily clinical practice.

Thus, the aim of this study is to investigate: What changes have mental health care professionals experienced in their own practice when facilitating a recovery-oriented program?

METHODS

Prior Understanding of Recovery-Oriented Mental Health Care

This paper's understanding of the concept of recovery from mental illness draws on the widely used and acknowledged conceptualization by Dr. William Anthony (Anthony, 1993). Recovery is conceptualized as the individual's personal process of living a satisfying, meaningful and hopeful life in spite of the effects of mental illness.

The literature on recovery-oriented services points out that the fundamental basis of these health care services is to support the person's recovery process by facilitating an active collaboration between the person with mental illness and the HCP. The professionals should infuse hope, support clients' decision-making, and help the client to improve their quality of life by respecting the individual's own choices and by involving the individual in his/her own recovery and treatment (Barker & Buchanan-Barker, 2011a, 2011b; Camann, 2010; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Davidson, Schmutte, Dinzeo, & Andres-Hyman, 2008; Farkas, 2007; Farkas, Gagne, Anthony, & Chamberlin, 2005; Slade, 2009).

Participants

To collect data from HCPs who have been providing IMR for a significant time as well as data from HCPs with a short experience of IMR, a selective sampling approach was used (Coyne, 1997). 16 mental health care professionals (HCPs) from the USA and Denmark were recruited. The participants were HCPs from the community mental health centers in New Hampshire, USA, where the IMR program was well-established, and HCPs from community mental health centers in the Capital Region of Denmark where the IMR had just been introduced.

The American HCPs were selected to participate if they had been formally trained and practicing IMR for at least 2 years at a community mental health center. Local site managers from the three different community mental health centers (named site A, B, and C) in New Hampshire, USA were contacted. After agreeing to participate, site managers then asked their HCPs if they wanted to participate; eight HCPs volunteered to participate.

In Denmark, the first eight HCPs to practice IMR in Denmark were invited to participate. They worked in one of two community mental health centers in the Copenhagen area (named site D and E). At the time of the interview, they had less than 1 year of experience with practicing IMR. All eight practitioners agreed to participate.

The HCPs varied in educational background and work experience. Table 1 includes a list of the 16 HCPs with detailed characteristics. Many were nurses, but psychiatrists, case managers, and occupational therapists also were represented. The HCPs work was similar across sites, and most had case manager responsibilities in addition to providing IMR. The IMR program was implemented as an “added” program along with a similar range of traditional community mental health practices in both countries. To keep the anonymity of the HCPs in the accounts quoted, they are identified by their country and study ID number, i.e. ‘USA1’.

Ethical Considerations

The New Hampshire Department of Health and Human Services Institutional Review Board approved the American part of the study (IRB reference # 199). In Denmark, an ethical approval is not mandatory in non-experimental studies. Nonetheless, the same level of ethical standards was applied in both countries: participation was voluntary, HCPs' confidentiality was maintained and the gathered information was used for research purposes only.