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The Rise and Fall of the Mental Health Recovery Model

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Abstract

The recovery model in mental health was the result of a number of coinciding events that include economic issues, social movements and consumer rights. This led to a new approach to mental health treatment. However the economic issues led to a new political agenda arising. Neo liberalism saw the decline in mental health consumers gaining empowerment and an equal share for the responsibility of their own treatment. This paper looks at a number of reasons why this model was introduced, the history behind it being introduced and why it has been largely ineffective in becoming a dominant model within mental health practice.

Keywords: Neo liberalism, Mental health recovery model, Deinstitutionalisation

Introduction:

The Mental health recovery has been a part of the mental health landscape for over forty years but has failed to be effective in improving outcomes for service users of mental health. This paper looks at a number of reasons why this model was introduced, the history behind it being introduced and why it has been largely ineffective in becoming a dominant model within mental health practice, including Neo liberal policies and economic necessities.

History

Psychiatric institutionalisation within Aotearoa / New Zealand had been seen as a failure, yet at it's peak, in 1972, thirteen public and three private psychiatric hospitals provided 10,000 psychiatric beds (Department of Health,1972). At this time, psychiatric hospitals were expected to handle the majority of psychiatric patients for the foreseeable future (Department of Health, 1969). Yet the purpose and success of psychiatric hospitals was slowly being challenged, evidenced by the apparent decision in 1963 to plan to build no more psychiatric institutions (Brunton, 2012). A national survey at this time recommended that 26 per cent of all patients with a psychiatric diagnosis be considered for placement in a range of accommodation settings outside psychiatric hospitals (Jeffery & Booth, 1974).

To counteract the move away from psychiatric inpatient services, from the early 1970's, psychiatric services began to concentrate on outpatient care, community-based treatment and the development of modern facilities (Brunton, 2012). This move was partly due to economic factors, the advent of psychotropic drugs and the counter-culture movements of the era, such as the anti war movement, woman's rights movement, anti racist movements, environmental movements and equal rights movements – which included psychiatric patients (Boyd, 2016; Knapp, Beecham, McDaid, Matosevic & Smith, 2011; Hirsch, Kett &Trefil, 1993).

Economic Reasons

Economically Aotearoa / New Zealand suffered when Britain finally joined the European Economic Community in 1973. At this time Aotearoa/ New Zealand's exports to the 'Mother Country' had fallen to less than 30% of all the countries exports. This occurred around the time of the first oil crisis when the cost of oil rose from US $3 a barrel to nearly US $20 a barrel. In turn this led to higher petrol prices which escalated to higher freight costs, higher costs for goods, higher wage rates and inevitably higher retail prices (Ministry for Culture and Heritage, 2012). As a result the Government needed to reduce its spending. Prior to this period the escalating expenditure on health and the inequity of health provision had become a source of economic concern for governments and the health sector. These issues were highlighted by a series of reviews from the 1950's beginning with the Barrowclough Committee (1953), The Department of Health review (1969), The Royal Commission on social security (1972) and 'A health service for New Zealand' (1975) (New Zealand Parliament, 2009).

Social Movements

Added to these challenges were the social movements of the 1960's and 1970's. The culture of this period was distinct from the post World War Two conservative lifestyle of the 1950's and there was a revolution of thought and a radical shift within the framework in most western cultures. Within this period there was a focus on the rights of individuals with both the civil rights movement and the feminist movement attacking beliefs and values that oppressed and limited groups within the population (Goodwin & Bradley, 2005). This generation was also shaped by powerful events including the war in Vietnam, the civil rights movements, the hippie movement, a newly emerging environmental movement, gay rights movements and populous music and drug use (Goodwin & Bradley, 2005; Dixon & Goldman, 2003).

Consumer Influences

The 1960's saw the establishment of the consumer/survivor/ex-patient movements (Morrison, 2005). This group was a diverse association of individuals who either were currently accessing mental health services (known as consumers or service users) (Morrison, 2005), or who were survivors of interventions by psychiatry, or who were ex-patients of mental health services (Corrigan, Roe &Tsang, 2011). From within the movement arose the recovery model - which sought to overturn therapeutic pessimism and to support sufferers to forge their own personal journal towards the life they wanted to live (Everett, 1994).

Health Professionals Influences

Within mental health a number of professionals also sort changes, including psychiatry, nursing and social work. Within psychiatry a movement arose which came to be referred to as the anti-psychiatry movement (Berlim, Fleck, Shorter, 2003). Anti-psychiatry was foremost a social movement that questioned not only the legal privilege of psychiatrists to detain and treat individuals with mental disorders, especially in a compulsory manner, but also the increasing "medicalisation" of madness. Anti-psychiatry also questioned the very existence of mental illness itself (Berlim, Fleck, Shorter, 2003).

In conjunction with the anti psychiatric movement, in the 1960s, saw changes continue between nursing and social work (Jones, 1963), with the formation of the New Zealand Association of Social Work in 1964 (Beddoe & Deeney, 2012). This was important as social work in health care in New Zealand had from its inception added the holistic dimension to health care (Auslander, 2001). Auslander's review of 100 years of health social work documents the move from the 'disease' paradigm (biomedical) to the social model of health (psychosocial) which takes into consideration social, psychological, spiritual, cultural and ecological factors of health (Auslander, 2001). This holistic approach of care was important for the recovery model as it conceptualises illness (and mental illness) as a complex interaction between the environment and the physical, behavioural, psychological, cultural and social factors which impact on health (Bracht, 1978; Bywaters, 1986; Lindau, Laumann, Levinson, & Waite, 2003). Bywaters adds that social work can assert 'the value of care as well as cure' (1986, p 670).

The Recovery Model

Within mental health the new model of recovery has a number of definitions, and has two main streams of thought. One definition is derived from the medical model and is described clinically and understood to be the return of the patient's former state of health. This is normally obtained by hospitalisation and medication (Petersen, Friis, Haxholm, Nielsen & Wind, 2015). Other definitions of recovery come from within the consumer/user/survivor movements of mental health and does not require, or focus on symptom remission or a return to normal functioning, as does the medical model. Within these definitions, recovery is expressed as a process of personal growth and development which can lead to regaining control of one's life, having personal fulfilment and a meaningful life (Davidson, O'Connell, Tondora & Evans, 2005). Another consumer/user/survivor definition describes recovery as being client-centred and having a client-directed focus, with the client deciding how their recovery is defined (Lukens & Solomon, 2013). From a holistic perspective Lapsley, Waimarie & Black (2002 p2) describe recovery as, "knowing who you are, and where you come from, and reintegrating yourself with your own people in your own way".

Recovery became recognised and a practised theory within mental health systems in a number of countries which included; United States of America, England, Ireland, Australia and Aotearoa / New Zealand (Schrank & Slade, 2007). Within Aotearoa/ New Zealand the recovery model was first introduced and promoted in 1998 through the 'Blueprint for mental health in New Zealand-how things need to be' and quickly became a main model of practice (O'Hagan, Reynolds & Smith, 2012).

The ‘Blueprint for Mental Health Services in New Zealand; how things need to be’ set out the need to remodel the mental health services to allow mental health consumers to be more actively involved in their treatment.

Aotearoa / New Zealand led the way in introducing such services as peer support programmes and peer led agencies, consumer support staff and family support staff within mental health inpatient units and was becoming a consumer focused and driven mental health service.

However within a a few short years Aotearoa / New Zealand has traversed back to a medical driven mental health service with only a few remaining relics of these initiatives left in place and are only symbolic with little impact (O’Hagan, Reynolds & Smith, 2012). Which led O’Hagan Reynolds & Smith (2012) to state that since the mid 2000's the recovery model concepts has been on the decline within Aotearoa / New Zealand. Yet this is disputed by the Ministry of Health (2014) who states that they are currently supporting recovery model practices.

The impact of the recovery model

With mental health in a flux of change, the degradation of service delivery and the move towards deinstitutionalisation, new models of care were being examined and saw the drive towards the recovery model (Mental Health Commission, 2001). The recovery model has been described as the first genuinely post-institutional service philosophy (Mental Health Advocacy Coalition, 2008) with Aotearoa / New Zealand being attributed as being the first country in the world to formalise ‘recovery’ as a national policy (Mental Health Commission, 2007).

The recovery model requires mental health service providers to enable service users to identify and develop their own strengths and resources and service users taking an active role in improving their lives and service delivery focused on making this possible (Martindale & Phillips, 2010; Mental Health Commission, 2001).

The recovery model has had an international impact on treatment for mental health with different countries introducing the model of care. Since 1998 all mental health services in Aotearoa / New Zealand have been required by government policy to use a recovery approach (O’Hagan, 2004; Jacobson & Greenley, 2001). In the United States recovery was primarily initiated by the Presidents Freedom Commission Report (Commissioner of Mental Health 2003). In Ireland the Mental Health Commission (2008) released 'A Recovery Approach within the Irish Mental Health Services. A Framework for Development' which introduced mental health recovery approaches after a four year review of the international evidence. The Australian government released it's 'National framework for recovery-oriented mental health services: Policy and theory' in 2013 (Commonwealth of Australia, 2013). This Australian national policy eventuated after including recovery in the National Mental Health Plan (2003-2008), but not as a national document as there was variation in service delivery between States and Territories (Rickwood, 2004). In the United Kingdom the National Institute for Mental Health (NIMHE) formally endorsed the principles of recovery in 2005, (National Institute for Mental Health, 2005). However there is currently no national government strategy or policy on recovery in mental health in the United Kingdom and the fundamental reason for NIMHE supporting the principles of recovery is “because that is what service users want, as it has the potential to provide patients with an enhanced experience of mental health services, to improve the quality of those services and to improve the outcomes of people who use those services” (Boardman, Goddard, Henderson, et al, 2010 p6). In Canada the 'Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada' was published and was first produced by the Mental Health Commission in 2009, and outlined a vision with broad goals for transforming the mental health system. This was followed by the same organisation in 2012 with 'Changing Directions, Changing Lives: The Mental Health Strategy for Canada' with the aim of presenting a way of understanding mental health, mental illness, recovery, and well-being that underpins the recommendations set

out in "Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada' and enhances the use of a recovery model within mental health (Mental Health Commission of Canada, 2012). However there is also no Federal policy on recovery-oriented services or policies within Canada, but Ontario has adopted a recovery focused approach to mental health (Canadian Mental Health Association, 2016).

All of these nations have based these mental health policy changes on the United Nations development on international human right obligations. Of relevance to this framework are the following international agreements; The United Nations universal declaration of human rights (1948), The United Nations Principles for the protection of persons with mental illness and for the improvement of mental health care (1991) and the United Nations Convention on the rights of persons with disability (2006) (Australia Government Department of Health, 2013).

The decline in the recovery model

Neo Liberalism

On a international scale the introduction of Neo liberalism was one of the major drivers of power and the shift away from Keynesian economic policies - which supported a welfare state supported by Government interventions (Palley, 2004). Historically Neo liberalism has been the overarching political driver since the 1970s with Margaret Thatcher (United Kingdom) and Ronald Regan (United States) instigating these policies which are now dominant within most western societies (Wynne, 2004). Neo liberal political policies, are based on neoclassical theories of economics, or the ‘Washington consensus'. The key elements of this consensus is on the privatisation of assets, outsourcing any services previously (or elsewhere) provided directly by government (Carpenter, 2000; Hartman, 2000). This model of governance relegates the state to setting policy goals and providing funding for services tendered-out to private sector providers, whether the service is for a minority population (like welfare or mental health care) or all citizens (such as local government refuse collection). Along with greater reliance on personal responsibility and civil society (such as non-government volunteer services), these measures remove the state from responsibility for service delivery and focuses on deregulation and tax reform which seeks to maximise the role of the private sector in determining the political and economic priorities of the state (Carney, 2008; Heywood, 2007; Kelsey, 1995).

Aotearoa / New Zealand

Aotearoa / New Zealand embraced Neo liberalism in 1984 with the election of the fourth Labour Government and commenced policies which included a large portion of state assets being privatised and those which remained in State control were expected to act as businesses within the private sector and produce maximum profits (Kelsey, 1995). Social services was further effected as Neo liberal ideas in Aotearoa / New Zealand brought considerable changes to the way society viewed social security (O'Brien, 2008; Roper, 2005; St John & Rankin, 2002; Kelsey, 1995, 1993). Social services and welfare provision were seen as reducing choice, creating disincentives to work, not supporting tax revenue and adding to the countries debt problems as successive governments borrowed to maintain social spending (Green, 1996). People who received or supported state funding of social services and welfare were portrayed as contributing to the moral decay and social breakdown (Green,1996).

This change in societal attitude saw a return of the old individual moral argument to explain why poverty, crime and other social ills occurred which was seen in early colonial times. The welfare state which had enjoyed many years of widespread social and government support came under serious attack and despite considerable evidence based research which warned of the dangers of cutting welfare provisions and social services (Gustafson, 1986; Oliver, 1977) Aotearoa / New Zealand faced a return to the residual model of welfare seen prior to 1938 (McDonald, 1998). This residual model of welfare, with its clear approaches to personal responsibility and moral order was directed by the state, and heavily influenced social services with its new ideas for success and failure, which included new models for social service provision (McDonald,

1998; Barretta-Herman, 1994). As a result the 1980s were characterised by strong tensions, both within and outside of Aotearoa / New Zealand between the calls for social justice and social action. Therefore Neo liberalism has not helped the recovery model as it has encouraged stigmatisation of the mentally unwell (Nash, 2007).

Yet despite these failings in 2015 the National Party led New Zealand Government announced plans to introduce 'Social Bonds' into Aotearoa / New Zealand and do so in mental health. The basis behind social bonds is to allow the Government to contract out services and funding to non-government or private organisations, with agreed targets and time frames, and if the targets are met, Government will pay back the investors, and also pays a return on their investment. The return to the investors depends on the level of results, up to an agreed maximum (Davison, 2015).

Reducing Services

Under funding and reducing services within mental health recovery models of care can reduce the challenge to traditional notions of professional power and expertise by preventing the break down of the conventional demarcation between consumers and staff that acknowledges and explores the power differences in the therapeutic relationship and their possible impacts (Australian Health Ministers Advisory Council, 2013). Therefore some organisations have seen the introduction of recovery based services as a way of reducing services and saving money (Slade et al. 2014). One way that the gradual reduction in contact with formal mental health services is undertaken is by contracting our service delivery and then applying funding cuts to organisations that provide these community services which were previously commissioned patient recovery (Slade et al. 2014). The reduction of services are often claimed by Neo liberals as removing ineffective services that need to be replaced or amalgamated with other service providers, but the reduction in services cannot be justified based on meeting the goal of being supportive of recovery as they reduce the power of consumers (Slade et al. 2014).

Conclusion

The recovery model in mental health has generally failed to provide better outcomes for patients and has failed to become a more inclusive and empowering model through the strong influences of Neo liberal policies. While western cultures, including Aotearoa / New Zealand continue to follow Neo liberal policies, mental health and mental health patients will continue to suffer, just as they have throughout history.

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