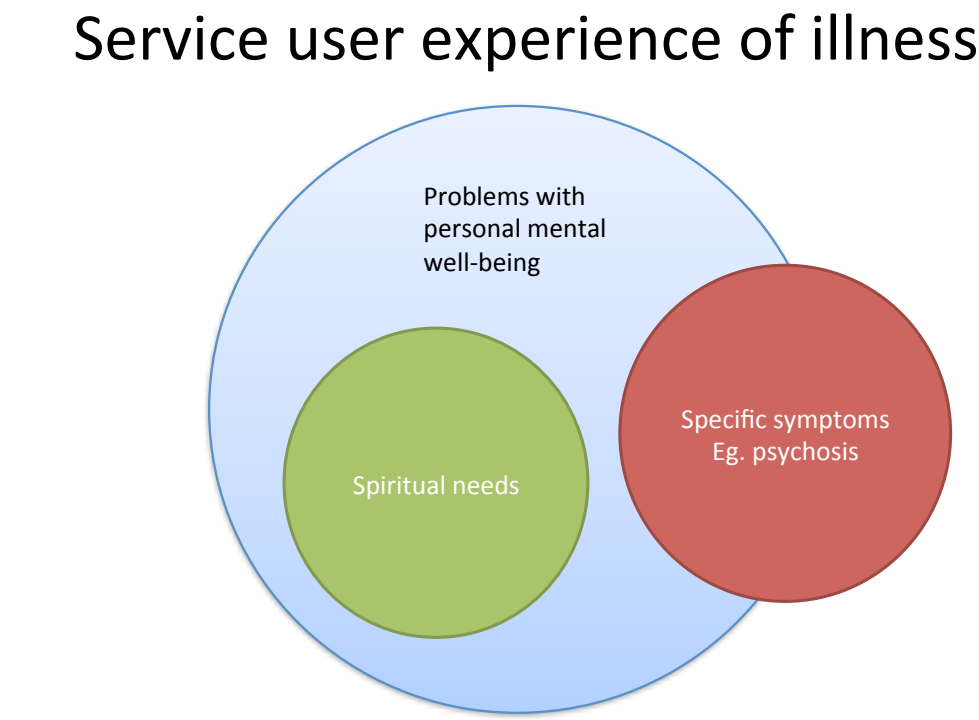
An exploration of personal recovery in mental health service users

What really is important for recovering service users?

Introduction



This research is an investigation of the process of mental recovery from mental illness from the service user viewpoint. We are calling this process: "personal recovery". Our project is inspired by 2 linked evidence-based concepts.

1. The idea that service users often have a different view of their own recovery from that of the clinicians looking after them. Some do not feel they are recovering despite being considered well by clinical staff.

2. The idea that many service users have spiritual needs which are not met by routine clinical interventions. Here, the spiritual refers to whatever gives meaning and purpose to life, whether or not it includes a specific religious faith.

We put these concepts together by hypothesizing that many of those people who are struggling with their personal recovery have, in fact, unmet spiritual needs. The aim of our work is to more fully understand the personal recovery journey, how it relates to clinical symptoms, what inhibits it, what promotes it and why some experience it less than others.

Development of the SeRvE

The Importance of the spiritual and the religious:

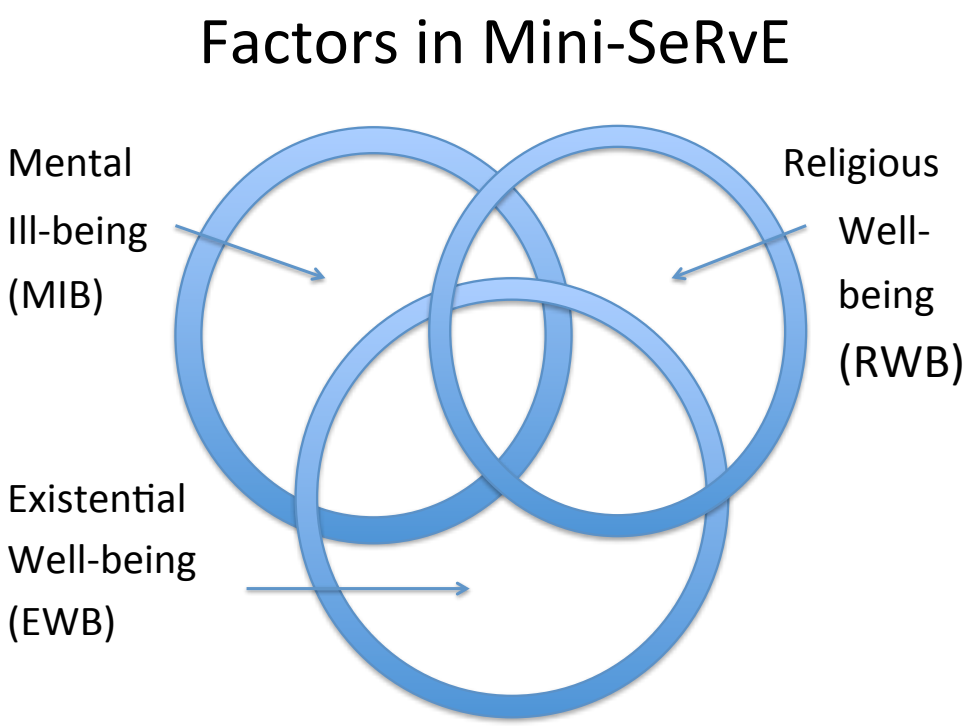
The first step in our project was to design a self-report new tool to measure personal recovery, (the Service user Recovery Evaluation Scale or SeRvE), so that it could be quantified and compared with clinical assessments over a period of time. The aim was to reflect issues that are of prime importance to service users for their own recovery. It was designed with considerable input from service users at Suresearch, both in the main meetings and more specifically in a subgroup - the Inpatient care forum. The research was led by a service user, also a member of Suresearch. A list of questions for SeRvE was compiled and completed by 100 service users in secondary care. Analysis of the results confirmed:

1. The importance of spiritual and religious issues.

2. The priority people give to positive issues rather than specific problems, or indeed, symptoms.

The finalized SeRvE scale has 40 questions and was shown to be a reliable measure of service user recovery. Further information about SeRvE can be found in ***Article 1 – SeRvE.***

Development of the Mini-SeRvE



SeRvE, although it could be useful for research purposes, is too long for routine or widespread use. It was therefore decided to create a shortened version, (Mini-SeRvE). This was done using a combination of statistics and qualitative input from the Inpatient care forum. Mini-SeRvE contains 15 questions, was completed by 100 service users and found to be a reliable measure of their recovery. During analysis, 3 meaningful subscales were identified:

1. Existential well-being, (things like meaning, purpose and hope).
2. Religious well-being, (how helpful you find your religion).
3. Mental ill-being, (things like agitation, stigma, isolation, lack of motivation).

Identification of these 3 themes is the central finding of the project so far.

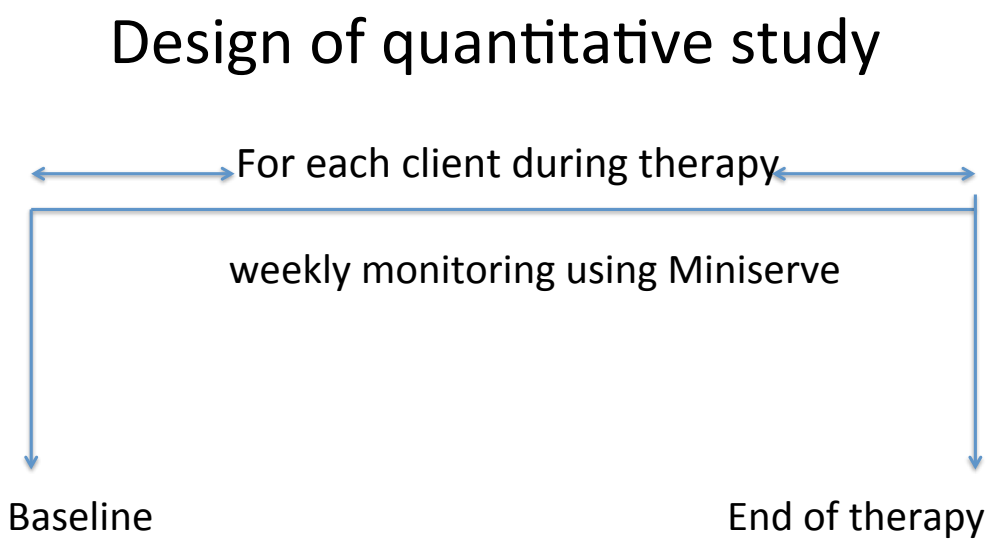
We then recruited 100 staff members in the Mental Health Trust to complete Mini-SeRvE. Overall, the staff members scored higher on Mini-SeRvE than the service user sample indicating their greater mental well-being and adding validation to Mini-SeRvE. For more detailed results, see ***Article 2 – Mini SeRvE.***

Importance of religion

There are many different world religions or faiths

During these 2 studies, we have built up compelling evidence for the importance to service users of a religion/spiritual belief. In both studies, analysis has revealed the importance of positive religious experience to our service user participants. Because of our interest in this finding, we took the opportunity of asking both our samples in the Mini-SeRvE project (service user and staff), to give a rating of the importance to them personally of a religious of spiritual belief from 1-5. Results showed that 55% of service users rated the importance of their faith to be “quite a lot”, (4), or “very much so”, (5). For the staff members this was highly significantly lower. The concept of the importance of religion/spiritual belief to service users is another crucial finding that we hope to take forward.

Next quantitative study



So far, we have developed 2 tools for measuring personal recovery in service users, (SeRvE and Mini-SeRvE). However, testing for sensitivity to change and test-retest reliability for these scales is necessary before they are fully validated for use. For this, it is necessary to make several measurements using these tools in the same people over a period of time. The counseling centre at St Martins church in Birmingham city centre is keen to use Mini-SeRvE for evaluation of their service and are willing to collaborate with us. Many of their clients are under either secondary or primary NHS mental health care. The usual duration of counseling is weekly for 6-12 weeks and clients already complete a measure of anxiety and depression each week. The idea is simply to add Mini-SeRvE to the existing measures. We will then be able to collect the data we need to calculate sensitivity to change and test-retest reliability for Mini-SeRvE. A detailed protocol for this is available in ***Protocol 1 - Quantitative***. We await advice about what sort of ethical approval will be required for this study.

Next qualitative study

All 3 concepts involved in personal recovery revealed by Mini-SeRvE analysis are poorly understood. We wish to investigate how these relate to the clinical assessment and to each other, and what promotes and inhibits progress in each area. For this, we propose a qualitative study involving semi-structured interviews with recovering service users to explore these concepts and how they change over time. We are particularly interested in what helps people find religious well-being. It is hoped that from this study, theories can be developed about the mechanisms involved in personal recovery. Most participants will be recruited via the Spiritual care team in BSMHFT. A detailed protocol is available in ***Protocol 2 – Qualitative.*** An ethics form has been completed for this study and will shortly be ready for submission for approval.

Conclusion

Eventual outcomes from all our work could include highlighting the value of spiritual care and informing its practice. It could even generate ideas for new interventions to facilitate all aspects of personal recovery in our service users