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An examination of a Recovery Group in an Adult Community Mental Health Team

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Summary

The recovery group provides an acceptable service which attendees' value and name as a helpful resource during their recovery journey. Replication of the group in other geographical areas could provide a valuable resource to support others in their recovery journey.

Introduction

Since its beginnings in the 1990s, recovery from mental ill health has been the model of care in many community mental health teams (Anthony, Rogers, & Farkas, 2003). Although recovery has different personal meaning to individuals, within mental health services it often refers to Anthony's (1993) conceptualisation:

> *"Recovery as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It's a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (p15)*

The concept of recovery in community mental health teams is also closely linked to observable outcomes such as reductions in symptoms and improvements in psychosocial functioning (Liberman & Kopelowicz, 2005). The combination of the process and outcome of recovery from mental ill health is commonly referred to as the individuals' recovery journey (Ramon, Healy, & Renouf, 2007). There have been a range of opinions in the understanding of the key elements of a recovery journey, mainly because every person's journey is unique to them. However elements such as connectedness, hope about the future, identity, meaning in life, and empowerment are commonly reported elements (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

How community mental health teams support individuals on their recovery journey can involve a variety of methods and services. This paper focuses on a recovery orientated weekly group, run in two locations by a single community mental health team. The group's primary aim was to support people on their recovery journey in a flexible way by provision of professional support, enhancement of people's support network by enabling peer support, and provision of information and education about recovery. The ethos of the group is of equal power membership, whereby members are encouraged to become peer support volunteers to democratically run the group with only background support. The group is run as a drop-in session where people can choose to attend on a weekly basis. Often optional short courses of focused education or information are run within the group which span six to eight weeks.

These have included completing recovery plans, education about healthy lifestyle choices, anxiety management, and a series of guest speakers relating to the local voluntary sector support network. The group was started in one rural town 18 months prior to this evaluation, and due to its popularity a second group was established 12 months later in a second outlying rural village. The usual group attendance ranged from 10 to 20 people in the primary location and two to six people in the outlying location.

The primary purpose of this evaluation was to determine if the recovery group was meeting its aim of supporting people on their recovery journey and if the service design was acceptable. The secondary purpose was to investigate the mechanisms underpinning the support, if the group was helping people on their recovery journey. This was to identify key elements of the recovery group which could aid development of similar services in other community mental health teams.

Three research questions were designed to attempt to fulfil the two purposes:

- Are the people that attend the recovery groups satisfied with the service(s) they have received?
- Has the recovery group helped the person on their recovery journey?
- What is it about the recovery group which has helped or supported the people that attend?

A mixed-method design was employed to answer the research questions using questionnaires and focus groups. All participants gave written informed consent, which included the use of anonymised quotes. Discussions with the hosting NHS trust provided permission for the evaluation and NHS ethics was deemed to not be required.

Method

Recruitment process: Attendees at both locations of the recovery group were invited to participate in the evaluation. Four weeks prior to the data collection, information leaflets detailing the evaluation were circulated to the group members. The principle investigator visited both groups two weeks prior to data collection to discuss the evaluation. This was to encourage participation in the focus group by familiarisation with the interviewer. The aim was to recruit as many members as possible on one single date to complete the questionnaire and to recruit up to five participants, from each location, to take part in the focus group (one at each location) one week later.

In total, 11 people completed the questionnaire across both sites, which represented 100% recruitment of group attendees on the data collection date. Five people attended the focus group run at the primary group location and one person was interviewed (due to low recruitment rate for the focus group) at the secondary group location. Demographic information is displayed in Table 1.

Table 1: Demographic information of particpants

	Primary Location		Secondary Location	
	Questionnaire	Focus Group	Questionnaire	Interviewee
Age Range	38-68	38-59	31-56	35
Gender				
M	3	1	1	
F	5	4	2	1
Ethnicity				
White British	8	5	3	1
Length of time at CMHT				
1 - 2 years	4	3		
2 - 5 years	2	1		
More than 10 years	2	1	3	1
Length of time attending group				
1 to 4 weeks	2	1		
2 to 6 months	0		3	1
1 - 2 years	6	4		

Questionnaire: Participants were invited into a second room, away from the main group, to complete questionnaires. The questionnaire comprised of a number of specific questions about the support that they had received, including the length of time they had been attending the group and support received from other professionals. Participants were also asked to identify how long they had been receiving support from the community mental health team and which group location they most regularly attended. The questionnaire also included the Client Satisfaction Questionnaire (CSQ-8) (Larsen, Attkisson, Hargreaves, & Nguyen,1979) and the Process of Recovery Questionnaire (QPR) (Neil et al. 2009).

Focus Groups: The focus groups used four prompt questions to aid a discussion about the recovery group. These were:

- What does recovery mean?
- In what way(s) has the recovery group helped you on your recovery journey?
- Would you recommend the recovery group to other people, and why?
- Overall, what is the most important thing that has helped your recovery journey?

Qualitative data from the focus groups was analysed using thematic analysis as described by Braun and Clarke (2006).

Results

Quantitative Data

Satisfaction: Overall participants indicated high levels of satisfaction. As shown in Table 2, there were no differences in levels of satisfaction between the two group locations. There were also no significant correlation between length of time attending the group and levels of satisfaction.

Table 2: Average of Questionnaires by Group Location

	Primary Location	Secondary Location
Satisfaction (CSQ-8) Maximum=32	27	27
Recovery (PRQ)*	71	77.6

Maximum=100

*Key: *Higher scores are indicative of recovery*

Recovery: There were no significant differences between the degree of recovery, as measured by the PRQ, between the two group locations. There was also no significant correlation between the length of time attending the group and levels of recovery. On inspection of the individual item average, two questions scored two standard deviations higher than the rest of the questions. This indicated that people agreed that they were basically strongly motivated to get better and meeting people who have had similar experiences made them feel better.

Qualitative Data

Focus group and individual interview data was analysed for emerging themes. See Table 3 for all identified themes by each question. Themes relating to the research aims are discussed below.

Table 3: Themes Identified by question

Question	Themes Identified
What does recovery mean?	• Process to getting better or managing better, • not going back to the person you were before, • acceptance, • building confidence, • talking to others
In what way(s) has the recovery group helped you on your recovery journey?	• A focus • Meeting others • Helping others • Making connections • Getting support • Feeling good • Not formal
Would you recommend the recovery group to other people and why?	• Yes • Yes – if in the correct stage of recovery • Shared experiences • Support from staff • Support each other • Non judgemental • Safe • Gain information • Doing different things
Overall, what is the most important thing that has helped your recovery journey?	• CPN • Friends • Connections/people at the group • The group in general • Talking to someone

Has the recovery group helped the person on their recovery journey?

Predominately people thought that the recovery group had helped them, however people also thought that the timing of attending the group had to fit within the person's stage of recovery.

Person B: you need to have hit the bottom and to have been at the bottom for a while, 'cause you can't deal with it all when you are still going down. It would be too much…. You have to want to get better.

Person C: It's about accepting and having the want and desire to get better

What is it about the recovery group which has helped or supported the people that attend?

As shown in Table 3, there were a range of themes that indicated how the group had helped people. One of the resounding themes related to making connections to others. People expressed that meeting people with shared experiences helped them to feel safe and not judged, something which they did not feel when out in public. Another key element was feeling that they were able to help and support others:

Person A: I came here thinking it was for myself, but no, it was to meet everybody else to help them along. It's like that gentleman I was helping a couple of weeks ago, when I got home that made me feel so nice. It's that, that has boosted me up, thinking that I am helping others, it gives you the incentive to come more and more.

People also expressed that the group was an important focus for the week:

Person F: It gets me out of the house and it gets me meeting people.

Person C: I wouldn't have been able to get out of bed this morning, if it hadn't have been for this place. I feel a bit of a responsibility to come here. It's a focus.

An interesting topic was the way that professional support was delivered in the group setting. Participants highlighted the flexible nature of support and how it felt more informal when accessed in the group. People expressed that because a member of staff was available it was easier to talk when problems arose, rather than needing to make formal appointments. This started to bridge the gap between relying on formal services and being discharged.

Discussion

The primary purpose of this evaluation was to determine if the recovery group was meeting its aims and if the service design was acceptable. Overall this evaluation has shown the both recovery groups were equally valued by the people who attend at each location. People reported that they were satisfied with the service that they were receiving and named the recovery group as a source of help for them during their recovery journey. It can be assumed that the delivery of the groups was acceptable as participants stated that they would recommend the group to others.

The secondary purpose was to investigate the mechanisms underpinning the support received from the recovery group. Key elements that the groups provide appear to be linked to helping to motivate and focus people on a weekly basis, providing access to peer support, developing the person's identity by providing a

valued helping role, and bridging the gap between relying on formal mental health services and discharge from services.

The main limitations to this evaluation were the design and low number of participants. The low numbers of participants reflects the sizes of the groups, however it has limited the ability to detect any statistical differences or associations. Due to the design of this evaluation it was not possible to investigate if the recovery groups altered the degree or pace of people's recovery. Therefore it is not possible to identify the effect of attending the group on patient outcomes. The recovery groups would provide an interesting, and clinically useful, longitudinal opportunity to assess how people's recovery alters during their attendance at either group. It would also be clinically useful to evaluate change in patient outcomes before and after attendance at the groups. Understanding the clinical effectiveness of the groups would help inform decisions relating to commissioning of further groups.

Conclusions

The recovery groups are an important and highly valued resource offered by the community mental health team. They support individuals in a more flexible way than other traditional services. There are clear elements that people have valued in their recovery journey which could be replicated in other locations. These include peer support, developing identity, providing a focus, and accessing support in a less formal way.

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