The Eagle

Cover art contributed by Mike Simon.
The eagle conveys the powers and messages of the spirit.

EDITORIAL

Concurrent Disorders and Recovery in Forensic Psychiatric Settings

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Recovery, Concurrent Disorders, Dual Diagnosis

Often, substance misuse and mental health disorders go hand in hand. Approximately one in five individuals with a mental health diagnosis also experience substance use issues. Many times, the substance use serves as a coping mechanism to help the individual deal with intrusive mental health symptoms or the inherent isolation that sometimes accompanies a mental health diagnosis. What is more, many individuals who experience concurrent disorders often find themselves struggling to receive the help they need within the forensic system. This current issue of the Journal of Recovery in Mental Health is devoted to a number of pertinent concepts in mental health, including facets surrounding concurrent disorders and forensic mental health. I am writing this editorial with my lived experience co-editor, Brian Rose, who leverages his experiences within the forensic mental health system as a peer support worker. In this role, he supports service users, educates mental health professionals, and represents change towards recovery-oriented practice. I have over a decade of professional experience conducting applied research within the addiction and mental health treatment context. It is on the basis of these experiences we feel we can provide a blended perspective on the concept of concurrent disorders and forensic mental health services which often go hand in hand. The articles contained in this issue provide perspective into a number of important issues surrounding these complex facets of mental health and recovery.

In my experience in Canada, the use of the word 'recovery' featured quite prominently in the realm of addiction long before the Mental Health Commission of Canada’s influential report Out of the Shadows at Last: Transforming Mental Health, Mental Illness and

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Addiction Services in Canada. In addiction treatment, the concept of recovery is an operationalization of what wellness looks like for any individual. Usually, the substance use issue is a surface manifestation of something deeper and more substantial—whether it be trauma, psychological issues, or mental illness. Therefore, the mere interruption of substance use is not enough to sustain long-term recovery. In order to address this, addiction treatment programs include extensive group, family and individual therapy, as well as peer support and spiritual components designed to enhance a sense of hope and connection. The key to this approach is the holistic nature of the conceptualization of the substance use disorder and its corresponding treatment. One cannot isolate the substance use from the individual. The individual exists within physical, mental, social, and cultural context. As such, the substance use disorder cannot be disentangled from these contextual factors. The same can be said for mental illness and its corresponding treatment.

There are many commonalities between the concept of recovery in mental health and addictions. For example, both mental health issues and addictions can be very isolating. I have heard quite often, and Brian can attest to this phenomenon, that many diagnosed with a mental illness or substance use disorder often feel like a ‘black sheep’ in their own family. If that is the case, this isolation can only be amplified within one’s community and in society especially when mental health and addictions continue to be misunderstood. Grappling with mental health and or addiction issues is only further complicated within forensic settings. The stigma associated with the forensic setting is difficult and often felt at the systemic level. Brian and I often talk about how individuals with mental health diagnoses are stigmatized; however, those within the forensic mental health system are the ‘stigmatized of the stigmatized’. Brian has bravely leveraged his experience within the forensic mental system to challenge these systemic and pervasive punitive attitudes to educate service providers and the community alike about the challenges faced by those found not criminally responsible because of their mental illness.

Indeed, there continues to be a stigma associated with both mental health and addiction issues, especially within the forensic context. Historically, addiction was seen as a moral deficit and a mental health diagnosis continues to be associated with labels and misunderstandings that often can do more harm than the symptoms themselves. That is why there is considerable power within the mechanism of peer support, both in addiction and mental health treatment. The addiction treatment field has a strong history of peer support. For example, the traditions within the 12-Step movement rely heavily on sponsors providing support and mentorship to those in early stages of recovery. This mutually beneficial relationship allows both members to gain a sense of connection and empowerment via one’s role as a sponsor or sponsee. Peer support is gaining considerable traction in Canadian mental health. Many mental health treatment centres understand the ways in which peer support specialists can complement traditional clinical treatments and employ such individuals for their lived experience. Brian is one such example. Brian was a service user, who was instrumental in the development and launch of one of Canada’s first Recovery Colleges and has since become employed as
a peer support specialist by the same organization that provided his mental health treatment. For Brian, there was much to overcome in order to recognize the value in sharing his experiences with those struggling with their own journeys. However, he finds that sharing his journey – both successes and challenges with mental health and addiction, has proven to be a valuable support to others and himself.

I am proud to work alongside Brian to blend both our experiences to enhance the quality of the services our hospital provides. However, in having experience in both addiction and mental health facilities, I am also struck by how much further the mental health sector can evolve in its use of lived experience. For example, like our hospital, I imagine those with lived experience make up a small fraction of employees within Canadian mental health treatment; and their lived experience is reflected in their job titles (i.e. peer support specialist). However, in my experience in addiction treatment facilities, I would say half of employees have lived experience with addiction and, for the most part, it is taken for granted. Many of the therapists, physicians, and even researchers I have worked with within the addiction field all leveraged their lived experience and blended it with their professional experience regularly. In this regard, I feel that perhaps stigmatizing attitudes or perceptions of them prevent mental health professionals from sharing their own lived experience with mental illness.

In his journey, Brian has experienced the fragmented nature of the mental health and addiction systems. Oftentimes, an addiction or mental health issue can serve as exclusion criteria for receiving treatment for the other. Individuals may find they are required to treat their concurrent disorders consecutively. However, addiction and mental health treatment is evolving; and recognizing that the concurrent disorders need to be treated together as one can lead to relapse of the other.5

Regardless of the differences, Brian and I agree that recovery, whether it be in an addiction or mental health context, shares several commonalities. For example, the CHIME framework illustrates components of recovery narratives for individuals with severe mental illness.6 This framework encompasses connection, hope, identity, meaning, and empowerment. Many of these facets of recovery from severe mental illness are also imperative for recovery from addiction. In her article, Bartram offers an integrated model of recovery that includes both addiction and mental health. Both contain the notion that recovery encompasses both clinical aspects and personal recovery aspects of wellness, and these exist along a continuum. Indeed recovery, whether it be in addiction or in mental health, is often non-linear in nature, containing both gains and setbacks. It is important to recognize that setbacks or relapses can often be a valuable learning experience and an integral part of the recovery journey.

As the concept of personal recovery grows and permeates within Canadian mental health care services, community and hospital-based treatment will continue to evolve to ensure it is holistic, inclusive, and culturally informed. As evidence continues to mount regarding the benefits of peer support, its inclusion will become more common. Canadian mental health service providers and researchers can learn extensively from
the gains made in Europe, Australia, New Zealand, etc. The global recovery movement is growing; and as researchers, policy makers, and mental health champions continue to challenge the way mental health and addictions are conceptualized and subsequently treated, the negative impact associated with the stigma that comes with a mental illness or substance use disorder within the forensic system or otherwise can be minimized.

Since its inception, the *Journal of Recovery in Mental Health* has touched on a number of important themes in mental health recovery. Specifically, the journal published articles related to global perspectives of recovery, recovery across the lifespan, recovery and the community, and best practices in recovery colleges. *The Journal of Recovery in Mental Health* is transitioning away from predetermined themed issues and is accepting original research, opinions and viewpoints, and lived experience manuscripts regarding all facets of recovery and recovery-oriented practice. Submissions for upcoming issues are welcome.

**References**

Remand Prisoners' Perceptions of Recovery in Closed Settings

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Abstract

Objective: Forensic settings offer challenges to traditional recovery approach principles. The aim of this article is to bring out remand prisoners' needs for personal recovery in closed institutions. The purpose of the research is to explore the reflections of remand prisoners’ experiences and needs for emotional and psychological ways of coping with imprisonment in the context of personal recovery.

Research Design and Methods: Ten people held on remand in prison were interviewed. The semi-structured interview was designed based on the main themes revealed in literature to support the recovery process in secure settings: relationships and connectedness with family and staff, emotional and psychological coping with imprisonment, a secure environment, and involvement in programs and activities. The thematic analysis made it possible to focus on participants’ perceived limitations and opportunities for personal recovery in a closed institution.

Results: Interviewees' reflections indicated that remand prisoners find it difficult to cope with social isolation, the lack of self-realization and overthinking. Being apart from family and having limited opportunities to communicate creates distress and worry, and culminates in a loss of connectedness. Negative relationships and perceived power differences with staff lead to tensions and create and confirm the identity “me as a criminal.”

Conclusion: There is a need to accomplish positive relationships between staff and remand prisoners. Creating more opportunities for prisoners to stay connected with loved ones and offering meaningful activities would lead to remand prisoners having better self-images, less stress, and more hope for the future in their return to society.

Introduction

A small but growing literature focuses on recovery in forensic settings.1,2,3,4,5,6
Forensic services offer challenges to personal recovery approach principles, particularly in relation to hope, empowerment, and individualism. Recovery within secure settings must deal with mental health problems, as well as violent behaviour. Clarke et al. conducted a systematic review of forensic patient perception of personal recovery, identifying six themes: connectedness, sense of self including separation from the ‘offender identity,’ coming to terms with the past, freedom, hope, health, and intervention. These themes overlap with Shepherd's findings.

**Research Context**

A large prison in Estonia consists of units that operate like small prisons. The study was carried out in a remand prisoners’ unit. At the time of research, the unit held 109 prisoners on remand, of whom 35% had been in prison more than a year and 11% more than three years without sentencing. People held in custody in prison have more restrictions than convicted prisoners. In Estonian law, they cannot have long-term visits and, if they do not have court-ordered bans, they are able to call home for at least 10 minutes per week, have short-term visits twice a month with glass separating them from visitors, and twice a year without glass if the prison permits. Most remand prisoners stay in locked two-person cells 23 hours a day with 1 hour of walking per day in an outdoor cell. Some prisoners held on remand who do not have court-ordered bans regarding isolation or security risks have the opportunity to go to school, participate in social programs, or work.

A prison social climate study recently done in Estonia concluded that prisoners were critical of all the evaluated dimensions including staff-prisoner relationships, well-being, personal autonomy, and family contact. On a scale of 1 to 5, none of the dimensions exceeded 3.5 and were mostly below 3.0. However, the research sample did not include remand prisoners, and for that reason, generalizations about the social climate in remand prisoner units cannot be made.

**Connectedness**

Positive relationships create a foundation for effective recovery and, furthermore, encouraging meaningful staff-patient relationships creates more effective security in forensic settings. The literature highlights a therapeutic relationship with family and staff as a key facilitator of the recovery process in forensic settings, being one of the strongest factors associated with positive functioning, and predictive of positive treatment outcomes. Family or partner visitations in prison improve individual adjustment and reduce stress. Being held in closed institutions can limit opportunities to maintain positive relationships. During long periods spent in forensic settings, service users often lose touch with family, get less support and, because of interacting with staff members on a daily basis, the role of staff in service user support becomes more important. Feeling valued, cared about, and respected by staff is more important for service users who spend a lot of time with them and have fewer opportunities for relationships outside of the institution. Developing a sense of self separate from the ‘offender identity’ is vital for recovery. The existence of positive relationships with family and/or staff is positively connected with the process of self-discovery, self-esteem, and the motivation to change.
On the other hand, relationships in forensic settings are more often poor than good. The negative effect of poor engagements with family or staff leads to a sense of powerlessness, lack of control, and loss of positive identity. Being treated disrespectfully or without dignity by staff generates negative emotions, such as anger, tension, indignation, depression, and rage, and correlates with institutional suicide rates. Experiencing stigmatization from staff can lead to self-stigmatization, which correlates with higher levels of stress, social separation, and loss of self-esteem and reduces hope for a better future.

**Improving connectedness and communication with staff and family**

Implementing the recovery principle in forensic settings by staff members might be viewed as ‘yet another training’ that entails extra work. Staff may show resistance to relating to prisoners as fellow human beings and treating them equally because it is easier to create a divide between themselves and those who commit crimes. Throughout a service user's stay in a forensic setting, there is a progression of relationships with staff influenced by everyday interactions. A lot of people in closed institutions have complex mental health problems with difficult social and family backgrounds, which can be demoralizing and psychologically hard on staff. This is the reason why more education and support are needed. People working in forensic settings must find a balance between supervising and supporting. Because of the challenges of implementing recovery-oriented relationships in forensic settings, there is a need for staff support, such as group and individual coaching and supervision, to promote reflective thinking and acceptance of these relationships by staff.

Some innovative ways to help convicted prisoners keep connectedness have been adopted around the world. Often innovative forms of face-to-face communication include only convicted prisoners due to stricter restrictions on prisoners who are being held on remand. In Singapore, prisoners have an opportunity to develop relationships with family in an open atmosphere on ‘Family Day’. A similar opportunity is offered in Estonia as well. In Italy, a non-governmental organization (NGO) organizes football matches inside prisons for prisoners and their children. In a prison in Wales, parents can be informed of and involved with their child’s well-being at school by meeting regularly with their child’s teacher, and in the Netherlands, fathers can play or do homework with children unsupervised in a family room. There are some innovative ways of communicating with family as well; for example, in the United Kingdom, some prisons have adopted voicemail systems to offer the exchange of messages more regularly, making communication more flexible. In the United States, a lot of prisons and jails offer the opportunity to Skype, but this is a replacement for face-to-face visits. However, since 2015, inmates at Magilligan jail in Northern Ireland have been allowed access to audio-visual technology as part of a new rehabilitation project and get an extra 30 minutes of video calling added to regular visits.

**Meaningful activities**

Being held in prisons causes great psychological strain on individuals, including depression, anxiety, insomnia, and somatization symptoms. On the other hand,
increased freedom on the wards and meaningful activities are essential factors in mental health recovery. Meaningful occupations should be viewed as a right rather than a privilege in prison settings. Learning new skills, education, and employment provide structure, restore a sense of value and purpose in life, give hope for the future, and provide opportunities to build a life beyond the secure setting, making the return to society seem more possible. Meaningful occupations enable prisoners to build new relationships and help to overcome social isolation in closed settings.

There is growing empirical literature on programs in prison that originate outside the criminal justice sector; for example, life skills training focusing on leadership skills. Creative arts therapy in prison has the potential to reduce depression and social isolation, increase problem-solving skills, promote personal transformation, and prevent the negative psychological effects of severe boredom. Yoga and mindfulness meditation programs delivered in prison settings reduce stress, help prisoners to manage anger and impulse control, improve self-esteem, and reduce mood disturbance. Engaging in sports regularly in forensic settings improves levels of self-esteem and interpersonal communication, and reduces anxiety, stress, feelings of depression and hopelessness, and insomnia. In addition, it reduces anger and aggression by providing an alternative outlet for physical tension. It has been found that playing sports can even be a key component in recovery from substance abuse.

**Research Design and Methods**

To learn about the individual needs and experiences of personal recovery and well-being in a secure environment, the authors designed a qualitative study with individual interviews. Thematic analysis was used as a method of analyzing data. Permission for research, including the interview questionnaire, and publication were granted by the Estonian Ministry of Justice. A list of the interviewees was approved by the prison unit manager.

**Interviews**

The interviews consisted of questions about relationships and connectedness with family and staff, emotional and psychological coping with imprisonment, the secure environment, and involvement in programs and activities. These themes overlap with Shepherd et al.’s identified themes that support the recovery process in secure settings: hope and social networks, a personal sense of safety and security provided by the physical environment and relationships with staff, and identity work. The main purpose of the research was to explore the reflections of remand prisoners’ experiences and needs concerning emotional and psychological coping with imprisonment in the context of personal recovery. The interviews lasted from 40 to 85 minutes. All interviews were audio-recorded and transcribed.

**Interviewees**

Ten participants were included in the study. The decision about sample size was based on the findings. The inclusion criteria of the interviewees in the research required them to have been in current custody in prison at least four months, to have
basic self-assessment skills, and to have the ability to communicate in Estonian. The participants were selected to create a range of different ages, lengths of stay, and number of times imprisoned before, in order to have a wider variety of answers. None of the invited participants declined the offer to participate in the study. The participants were asked their permission to record and use their answers anonymously.

All participants were male and between 25 and 63 years old; the average age was 38, and participants have been held in custody in prison between 4 and 39 months; the average at the time of the interviews was 18 months. Two participants were in an Estonian prison for the first time, and the others had been imprisoned in Estonia before, between one and four times.

Data analysis

Data was analyzed by using thematic analysis. The aim was to find interpreting pattern meanings, or themes, across the interviews. According to Clarke and Braun, themes provide a framework for forming and organizing the researcher’s analytic observations. After transcribing, the first author generated initial codes for emerged patterns in the data. Coding began with multiple readings of the transcripts. The first author then analyzed the codes and looked for border patterns of meaning. The next step was to return to the initial material, read it again, and make sure that all themes and codes were well covered and that no data had been missed in the prior coding stages. Finally, both authors analyzed the codes and further defined and named the themes. This resulted in five key themes and multiple sub-themes. Based on the illustrative and communicative capacity, key quotes were carefully selected.

Results

Interpersonal processes related to the physical environment

Isolation was an important theme for most participants. During the interviews, two elements related to interpersonal processes were described: (1) social isolation and inactivity, and (2) the process of change in identity.

Social isolation and inactivity. Participants described how not knowing how long they would be in prison or what would happen next was a source of stress. Most participants described how a lack of self-realization was mentally hard on them. Being isolated, the lack of changes and not being able to make decisions about everyday life got worse over time and created stress, numbness, or a lack of emotion, or even made them feel powerless and like they were disappearing.

“Here it’s especially crazy, you are here with one other person ... you are isolated, canned, ... you fade away in that cell. I understand you read and stuff ... but this sameness kills; you end up like a vegetable.”
On the other hand, in contrast to social isolation, some participants described how a lack of privacy and limited opportunities to be alone were emotionally difficult. Almost all of the interviewees described how isolation led to overthinking. Participants said that it was hard for them to turn their thoughts off and to get rid of bad thoughts. “You go to sleep with one thought and you wake up again with the same thought.”

Most participants talked about consciously suppressing or hiding negative emotions due to not trusting their cellmates enough to express their emotions to them. Some participants described how overthinking and suppressing emotions led to high stress levels. Furthermore, suppressed emotions tended to burst out and that led to negative and unwanted consequences that affected people around them, including their cellmates and relationships with them. “It grows and grows and then things happen that you actually don’t want to happen.”

**Process of creating identity during imprisonment.** Positive and negative relationships influence remand prisoners’ self-stigmatizing and identity. Some participants described how being held on remand reduced their dignity and created a ‘me as criminal’ self-image. “I’m here like a criminal, drug offender, alcoholic, junkie … I’m like a useless stain.”

**Connectedness with friends and family**

Most interviewees described being incarcerated as having a negative effect on their relationships. During the interviews, three tendencies related to connectedness with friends and family were described: (1) perceived absence from family, (2) relationship dynamics, and (3) reasons for distancing. Participants described relationships with friends, parents, siblings, wives, and children.

Worry and perceived absence from loved ones was a common theme. Almost all participants said that the hardest part of being in prison was being apart from family members, which created negative emotions and stress. “Mentally the hardest part of prison is being away from loved ones, from a child.”

Interviewees said that knowing that family members were not doing well and not being able to do anything to help was psychologically hard on them. Moreover, participants said that having limited opportunities to support family during hard times made them feel helpless and increased concern and stress. “I went to work, I took care of my baby….now I can’t even send toys for Christmas.”

**Dynamics of relationships with loved ones.** Interviewees described their relationship dynamics with their life partners. New relationships without common children tended to fall apart. Even when relationships lasted, participants still described losing connectedness. Relationships with children suffered most. If the children were young and the time spent in prison was long, the father and child lost their emotional connectedness. “Relationships are getting distanced, daughter asks when I will come, when I will come, fourth Christmas are going by.”

Most participants prioritized their family members over friends. On the other hand, some interviewees claimed their relationships were getting stronger while they were
incarcerated. This was particularly the case with people who had addictive disorders and negative relationships with family because of using drugs. Now that they were sober, their relationships were getting better. “I had a lot of disagreements with my mother, because of using ... now it’s easier for her. She doesn’t have to worry if I have overdosed or not.”

**Reasons for becoming distanced from loved ones.** Due to a lack of physical closeness, some participants who had been in prison for a long time described losing emotional connectedness with parents or siblings, even though they called and wrote regularly. “This week for the first time [in 3.5 years] I got to see my family, my mother and sister, with no glass in between us. I felt weird hugging them.”

Some interviewees claimed to feel distanced from their families due to not wanting to share bad news with them or because a child had been lied to about where the father was. They tried to protect their loved ones from sadness and extra worry. Some interviewees described losing emotional connectedness with children due to complicated relationships with ex-wives or due to court-ordered bans on calling or writing letters to people outside of prison.

**Valuing relationships with staff**

The quality of relationships between the staff and the interviewees was brought up in all interviews. During the interviews, two categories related to relationships with staff were described: (1) perceived attitudes, and (2) impacts of negative relationships.

**Perceived attitudes.** When asked to describe the quality of the relationship with staff members, there were two types of answers: “normal” or “bad.” Most participants felt that staff members were arrogant or excessively authoritarian towards them and that they thought little of the prisoners. Some interviewees said that they felt a huge gap between staff members and prisoners and they did not feel equal in the relationships. “You are prisoner, a criminal, and you are nobody to us. This is how they look at you.”

Some participants said that they felt like staff members did not care about their problems or concerns. Some participants said that there were two types of staff members: “those who do their work with their hearts and souls, and those who do not. Some guards come and talk and you can see that they are worried, but some will just say that they don’t know and bang on the door.”

**Impacts of non-helpful relationships with staff.** Negative relationships between detainees and staff can lead to tragic consequences. One participant described how he considered harming himself to get revenge. “As an act of protest, I have considered self-harm because of conflict with the staff members.”

Suppressing emotions and overthinking can lead to emotional explosions. Some participants described how they unloaded their emotions, and sometimes all of their accumulated negative feelings burst out at the staff. Interviewees understood that a staff member might not have done anything wrong, but this was the safest place to
unload emotions. “I might say something bad to someone, even though it wasn’t his fault directly, but I don’t have anybody else to unload on.”

Some participants who had been held on remand for years described the staff’s attitudes towards inmates as changing over time. They said that when a new staff member was hired, his attitudes toward remand prisoners became colder and less caring after a short period of time.

**Practical solutions**

Participants described solutions that would help them to recover and develop in order to change their lives: keeping connectedness with friends and family and reducing stress and negative emotions. Solutions can be categorized as (1) activities outside of the cell, and (2) improving relationships with family and staff.

**Activities for well-being.** Some participants described uncertainty about the future. Most participants who were afraid of the future had substance use disorders. Some participants described being lost and looking for directions. Almost all participants described a lack of social rehabilitation and the closed cell policy as having negative effects on their return to society. “I would like to remain a human being, maybe there is some other way. Maybe I will find it. I won’t find it in the cell.”

The need for self-development to feel more optimistic and confident was brought up in most interviews. Some participants expressed a desire to change their lives. Some participants described how mental stimulation helped to overcome negative emotions and stress. The opportunity to go to school or be involved in social programs helped them to feel self-fulfillment and reduced feelings of being isolated. Almost all participants who had been in group programs gave positive feedback and said the programs gave them a better sense of themselves and direction for the future. Some participants said they needed practical knowledge that would increase their ability to manage their lives better in society, like gaining new work experience, higher education, or learning new professions. “I have a secondary education, and I would really, really like to have a university degree.”

When asked what they did with negative emotions and feelings, most of the participants said that they tried to do something that took their minds elsewhere. But it became apparent that interviewees did not believe they had a lot to do in their cells. Almost all interviewees said they watched TV, read books or did sports, “but that does not help that much,”

Participants said that a good stress reliever was getting out of their cells. The only activity out of their cells that everybody could do was to go outside for a walk. Some participants described walking in the outdoor area as calming and positive for their moods. “I go outside every day because when I come back I feel so much better, my mood is better.”

Most participants said that physical activity was important for them, and an opportunity to go to the gym or to do sports had a calming effect and helped them to overcome negative emotions, such as anger and sadness. It also provided
opportunities for self-realization. “It takes tensions away. It makes things easier for prisoners. There shouldn’t be such rigid situations….every physical activity drives away bad thoughts.”

Some interviewees had started to do yoga or meditate in prison. They said that meditating gave them an opportunity to turn thinking off, had a calming effect, and taught them how to manage emotions. Some participants expressed a wish for group yoga due to a lack of space and silence in their cells.

Solutions to improve relationships with family and staff. Almost all participants said family support and talking with family helped them to cope emotionally and reduced stress. Some interviewees described how talking with people from outside of prison gave them positive energy and the motivation to keep going. Moreover, talking with family members not only reduced negative emotions but helped to maintain positive relationships and to re-socialize after being released from prison. Most of the participants said that they did not have opportunities to talk with their family members as often as they needed to keep connected. Most interviewees felt that phone calls and short-term visits should happen more often and with flexible hours. They described circumstances when it was hard to contact family members during work hours. Some participants added that opportunity to make video calls would add extra value to the communication with children and would give the opportunity to communicate with people who are not allowed short-term visitations. “If only she didn’t go to kindergarten. I haven’t heard her voice for half a year.”

Furthermore, almost all participants felt that having the opportunity for long-term visits or more occasions to talk with their loved ones in an open atmosphere, without glass in between, would help them to keep connected and to release suppressed emotions. Some interviewees with small children said that they were afraid of the negative psychological effect on children of talking through glass.

Some participants said that talking with a specialist, such as a psychologist, social worker, or chaplain, in prison helped to reduce stress. They expressed a desire to have this opportunity more available. “When I get out [of my cell] to talk with you, then it automatically makes me feel better; I talk, try to be positive. I forget other thoughts for a while.”

Some participants expressed a wish for equal and compassionate relationships with staff members. They felt that communicating without power differences and with empathy would help to create a better atmosphere and that would lead to better relationships and reduce negative tension on both sides. Some interviewees described their communication with staff members as ‘mechanical.’ “When you deal with mechanical processes … it is irritating.”

Individualized approach. Some participants described the need for an individualistic approach and felt like the treatment in prison was too generalized. They said that a more individualized approach would help to create positive change to manage their lives better after being released from prison. Participants who had been held on remand for long periods felt like there should be more support services and opportunities for them. “I think it’s not fair to compare my situation with an
average person. The average arrest is six and a half months” [he had been held on remand for 39 months].

Also, some participants described their desire for a more individualized approach to helping with substance use disorder. Interviewees who were not allowed to take part in group programs or go to school due to court orders or security risks felt that there should be other opportunities for self-improvement.

Discussion

Connectedness

Positive relationships with family and staff have been highlighted as a key factor in forensic care recovery. In the current study, it became apparent that talking with family was one of the relievers of stress and suppressed emotions, whereas the interviewees reflected that the loss of positive relationships led to negative emotions, social isolation, numbness and increased tension, and stress. Mentions were made of relations with both family and staff members. This is consistent with studies that show that regular family contacts reduce depression symptoms and strain. The participants also reported losing connectedness with family members due to being held on remand. Even when relationships lasted, participants still described losing connectedness. Relationships with children suffered most.

On the other hand, connections might be harmful if they are perceived as degrading ‘they look down on us’, uncaring, not understanding ‘they don’t care about my problems,’ or ‘excessively authoritarian’. That was often the case with participants, although we cannot draw general conclusions regarding participants' perceptions of staff attitudes because of the small-scale study. Everyday interactions provide a mirror to develop self-image and identity. In a closed institution with limited opportunities to socialize, interaction with staff members becomes more important. This is the case especially for remand prisoners. In forensic settings, personal recovery not only includes separating oneself from illness, but also from ‘offender identity’. In the current study, it became apparent that everyday interaction with staff members might intensify or create the self-image of being a ‘criminal,’ ‘alcoholic,’ or ‘junkie’ and weaken the self-image of being a father or a valuable member of society.

New solutions

Participants described how the lack of changes and social isolation got worse over time and created stress, numbness, or a lack of emotion, or even made them feel powerless. In the current study, in the author’s opinion, participants did not express a desire for any unrealistic and unreasonable opportunities. Desires were in fact quite modest. Most of the measures participants described were either better opportunities to communicate with family or activities outside of the cells. Almost all new measures participants described were based on specific needs and were explained clearly, for example allowing phone calls two to three times a week instead of once a week, and with more flexible hours to better fit family members’ work and school schedules. Participants did realize that they were under investigation and could not have contact with some of the co-prisoners. To reduce social isolation, they
suggested more group programs where they could select people they could have contact with. Or instead of only one person walking in an enclosed outside area, a few people could walk at the same time. Most participants brought up the opportunity to do more sports, but even then, the desire was not for a high quality gym, but rather pull-up bars or a little more room to do exercises. Suggestions about sports and other activities outside of the cells, such as group yoga and meditation, were based on participants’ own positive experiences. In the current study, the participants had developed new coping strategies and self-care methods to maintain psychological balance. Some participants said they had started doing yoga or meditation in prison. Interviewees said that physical activity and meditation helped to deal with the negative psychological effects of a closed environment: “It takes away bad thoughts and reduces tension.” This is consistent with studies that show that meditation and sports reduce stress and feelings of depression. The meditation opportunities helped to develop self-awareness and encourage the development of self-care. Participants had quite good understandings of what was helpful in maintaining psychological balance or was good for recovery, but they had limited opportunities to engage in these activities.

Hope has been highlighted as a key factor in recovery, but forensic services offer challenges to some recovery approach principles, including hope. One opportunity to increase feelings of hope in remand prisoners is to make meaningful activities more available. In the current study, the participants valued the opportunity to go to school, to work, or to be involved in social programs. The study and work opportunities could provide new roles. New knowledge helped prisoners to regain a sense of control and also increased hope and optimism about the future. Clarke et al. mention that the opportunity to develop new skills and demonstrate personal achievement nurtures a sense of self-worth.

Estonia is an innovative country, especially in the field of technology. The Consumer Technology Association (CTA) announced that Estonia, among 16 other countries in 2019, led the world in having the best environment for innovation. However, this is not reflected in prison settings. For example, Estonia, the inventor of Skype, does not provide opportunities to make video calls with family in prison, although a lot of other prisons and jails have done this for 20 years. Even when Estonian correctional institutions use innovative technical measures, they are not used to contribute to prisoners' social and psychological well-being. However, thanks to Estonia’s innovative mindset, it is possible in the future if this use will be seen as a necessity.

Limitations

This study has some limitations. The qualitative methodology and thematic analysis made it possible to focus on participants' perceived limitations on personal recovery in a closed institution, but the results were drawn from a small-scale study, so they cannot be generalized. Not all of the participants have had experience with mental illness, but the closed environment did cause great psychological strain.
Conclusion

The aim of this article was to bring out remand prisoners' needs for personal recovery in closed institutions. Remand prisoners find it difficult to cope with social isolation, the lack of self-realization, and overthinking. Perceived negative relationships with staff members create division and tension and lead to creating and confirming the identity ‘me as a criminal.’ Being apart from family with limited opportunities to communicate creates distress and worry, and culminates in a loss of connectedness. Participants expressed a need for promoting more recovery-oriented communication with staff that avoids power differences and more opportunities to communicate with their loved ones. Meaningful activities are essential factors in recovery. The current study found that having meaningful activities available would nurture a sense of self-worth and self-efficacy, participants would be more hopeful about the future, and activities would provide opportunities to build lives beyond the secure setting, making positive returns to society more possible.

Acknowledgments

The authors declare no conflicts of interest.

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Consumers’ Perceptions of Nurses Using Recovery-focused Care to Reduce Aggression in All Acute Mental Health Including Forensic Mental Health Services: A Qualitative Study

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KEYWORDS
Psychiatric Nursing, Recovery-Focused Care, Aggression, Forensic Mental Health

Abstract

Recovery-focused care is now the preferred model of care that health professionals can utilize to support people with a mental illness to achieve their personal and clinical recovery. However, there remains a lack of practice guidelines and educational opportunities to support nurses to use recovery-focused care with consumers who may become aggressive.

Objective: This paper reports the findings of research conducted with consumers to obtain their perception of how nurses can use recovery-focused care to reduce aggression in all acute mental health including forensic mental health services.

Research Design and Methods: Thirty-one people diagnosed with a mental illness participated in this study. The constructivist grounded theory method guided data collection, coding, and analysis to generate categories that described the consumer perspective.

Results: Five categories emerged, and these were: 1) see the person as an individual with a unique lived experience, 2) dialogue to explore the reason for the behaviour, 3) use positive communication to encourage self-management, 4) promote personal comfort to de-escalate the risk for aggression, and 5) travel alongside the person to co-produce strategies for reducing aggression.

Conclusion: The findings may be tested in future research to translate recovery principles into acute mental health settings. They can also be incorporated into nursing

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education and professional development training to increase understanding of consumer perspective of recovery-focused care in all acute mental health including forensic mental health services.

Introduction

The use of recovery-focused care (RFC) by health professionals is endorsed in mental health policy in many countries as a way to support people with a mental illness to be fully involved in decisions about their care.1,2,3 RFC is based on the premise that having a mental illness is only one aspect of the person’s life, and empowering and supporting them to mobilize their strengths and resources can assist them to build a positive sense of self-identity, find meaning and purpose in life, and foster hope for the future.4,5,6 Central to RFC is the philosophy that recovery from mental illness is not an absence or reduction of symptoms, but a personal change in the person to take control and responsibility over their life.7,8 Health professionals need to use RFC in all acute mental health settings including forensic services,9 as this will move the focus of care from the traditional medical model approach to a model that empowers consumers to be more involved in their own care and that supports their recovery journey.10,11,12

In all acute mental health settings, nurses have a continual presence in the ward environment and are uniquely positioned to support consumers to achieve their personal recovery goals.13,14,15 However, the occurrence of aggression can impact on nurses’ willingness and ability to establish a therapeutic relationship with the person.5,16,17 Aggression is dysregulated behaviour that manifests as, or results in, threats or injuries to self or others, or damage to objects or property.18,19,20 Previous research that examined the triggers for aggression grouped them into 1) person-related factors such as the person’s mental illness, personality, or substance abuse, 2) environment-related factors such as layout, space, location of ward, type of regime, or organizational routines, and 3) interpersonal factors such as interactional methods and staff variables.18,21,22,23

The consumer’s lived experience when admitted to an acute mental health setting can also trigger aggression, but it is not an interactional factor routinely recognized by health professionals as a potential trigger for aggression. Nevertheless, the literature highlights that consumers can feel helpless, vulnerable, frustrated, and anxious about their future, which may all be precursors for aggression.24,25 Consumers who developed negative feelings during admission are more likely to use ineffective communication styles, which can lead to a greater likelihood for interpersonal conflicts.18,21,26,27 Assessing and having an understanding of the person’s lived experience is important to the provision of nursing care.28 However, a thorough assessment by health professionals to gain an informed understanding of the person’s lived experience is currently not routine practice.29 Consequently, challenging behaviours that were triggered by the impact of the consumers’ lived experience may be viewed by nurses as resulting solely from the consumer’s mental illness, leading nurses to focus on behavioural and symptom management.30 They may also be less optimistic to use therapeutic engagement
strategies, such as positive communication, verbal de-escalation, or anger management to support consumers to self-regulate their own behaviours. Hence, they may implement more restrictive practices, such as enforced medications, restraint, and seclusion. However, choosing these restrictive options to manage aggression is in direct opposition to the philosophy of RFC.

Nurses who use RFC can obtain a more person-centred assessment of consumers’ triggers for aggression, and thereafter support them to utilize their own coping mechanisms to reduce their potential for aggression. This will facilitate the therapeutic relationship and increase consumers’ involvement in their care to minimize the intensity of their negative feelings. As there is a lack of practice guidelines on how to embed RFC within contemporary nursing practice, its use is currently dependent on the knowledge, skills, and confidence of each nurse to practise RFC. This paper contributes to literature in the area and reports the findings of a qualitative study which explored consumers’ perceptions of how nurses can use RFC in all acute mental health settings to reduce the potential for aggression.

Research Design and Methods

Ethics approval to conduct the research was obtained from Curtin University Human Research Ethics Committee—approval number HR132/2015, and one health service in Western Australia. Grounded theory methodology guided the process of data collection, coding, and analysis to generate categories that accurately interpreted participants’ perspectives of how nurses can use RFC to reduce aggression. The researchers did not set out to develop a substantive theory but used grounded theory methodology to guide data collection, analysis, and write-up of findings. This is to ensure that the emerging categories were grounded in the participants’ social and psychological process of the studied phenomenon. The use of the constant comparative method of analysis central to grounded theory also ensured that each participant experience was compared with others and all participant experiences were captured.

Data Collection

Data were collected by the first author from June to October 2017 using semi-structured interviews and three focus groups with consumers. Consumers identified by their treating team as being able to participate in the research were given an information sheet by their case manager. The information sheet outlined the details of the study and what their participation involved. Individuals who told their case manager that they would like to participate gave their permission for the research team to contact them and were given time to ask any questions they had prior to their involvement in the research. All participants provided written consent to be interviewed and to have their dialogue digitally recorded. An interview guide, which included a brief explanation of RFC, was used to guide data collection.
Purposeful sampling was initially used in line with grounded theory methodology to recruit participants who 1) were 18 years or older, and 2) had experience of being hospitalized in an acute mental health setting, including forensic mental health settings. Theoretical sampling was then employed as the categories started to emerge through concurrent data collection and analysis. This enabled different or expansive experiences of the phenomenon under investigation to be captured, for example younger participants (age 18 to 24) who had limited admissions to hospital, and people who had been hospitalized regularly during their lives and had seen many changes in care during this time.

**Data Analysis**

All interviews were transcribed verbatim by the first author and were checked by the second and third authors to ensure that data were accurate and detailed in descriptions of participants’ experiences. The constant comparative method of analysis central to grounded theory was used to code each interview data, compare data between participants, and to build categories. The coding procedure outlined by Charmaz was employed—initial coding and focused coding constructed the analytical categories. In initial coding, data were analyzed line-by-line and in segments and assigned labels to build initial codes. In focused coding, initial codes that were most significant were used as provisional categories for comparisons with new interview data to consolidate the emerging categories. Validation of the coding process and emerging categories was obtained through checking of data and coding by the second and third authors. Data analysis ceased when all the categories were well-developed and rich in participants’ experiences.

**Findings**

Thirty-one people diagnosed with a mental illness participated in this study. Participant demographic data is presented in Table 1. The individual interviews lasted between 10–48 minutes (mean = 17 minutes) and the focus groups lasted between 30–45 minutes (mean = 40 minutes).

<table>
<thead>
<tr>
<th><strong>Table 1. Demographic Data of Participant</strong></th>
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<tbody>
<tr>
<td><strong>Total number of participants</strong></td>
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<tr>
<td><strong>Gender:</strong></td>
</tr>
<tr>
<td>Male</td>
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<td>Female</td>
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<td><strong>Age groups:</strong></td>
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Many participants described aggression occurring in all acute mental health settings as a form of maladaptive behaviour that some consumers displayed when they were overwhelmed by the intensity of their emotions during hospitalization: “When people are in distress, they can feel helpless and trapped [in the ward environment]” (P12). The behaviour also occurred when nurses did not take time to explore and address the consumers’ lived experience: “Sometimes they [consumers] think that [nurses] don’t care” (P7) and “[the negative emotions] can start bottling up and it is going to get to a point where the bottle is full and then they explode [become aggressive]” (P10); “They want to express themselves, but they can’t, so it will be expressed by acting up and throwing things” (P11). There was a consensus among participants that RFC was effective for reducing aggression and five categories and their subcategories that defined consumers’ perceptions about the use of RFC were identified. They are listed in Table 2.

**Table 2. Consumers’ Perceptions About the Use of RFC**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
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<tbody>
<tr>
<td>1. See the person as an individual with a unique lived experience</td>
<td>• Recognizing different triggers for aggression</td>
</tr>
<tr>
<td></td>
<td>• Respecting the individuality of each consumer</td>
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<tr>
<td></td>
<td>• Empathizing with the consumer’s feelings</td>
</tr>
<tr>
<td>2. Dialogue to explore the reason for the behaviour</td>
<td>• Focusing on the consumer’s reason, not their behaviour</td>
</tr>
<tr>
<td></td>
<td>• Cultivating a therapeutic relationship</td>
</tr>
<tr>
<td>3. Use positive communication to encourage self-management</td>
<td>• Focusing on the consumer’s strengths</td>
</tr>
<tr>
<td></td>
<td>• Promoting self-management of behaviour</td>
</tr>
<tr>
<td>4. Promote personal comfort to de-escalate the risk for aggression</td>
<td>• Implementing care for a consumer holistically</td>
</tr>
<tr>
<td>5. Travel alongside the person to co-produce strategies for reducing aggression</td>
<td>• Understanding recovery in mental illness</td>
</tr>
<tr>
<td></td>
<td>• Focusing on the consumer’s personal recovery</td>
</tr>
</tbody>
</table>
Category 1: See the Person as an Individual with a Unique Lived Experience

Participants explained that nurses needed to see each consumer as an individual with a unique lived experience, personal traits, and differences despite having the same psychiatric diagnosis as other consumers in their care: “Everyone is human and we all have our own [lived experience] and no two people are the same” (P13);

“Everyone is different, and we are not all going to be coming in with the same [personal challenges]. We have all got a different situation [leading up to the acute admission], so [nurses] need to acknowledge that everyone has got different things going on [in their lives] and to [acknowledge] each person individually” (P12).

Participants perceived that nurses who did not have an appreciation of them as individuals with unique lived experiences could easily misjudge their behaviour as only related to their mental illness: “There was a kid who they [nurses] said he threatened a staff member when he just waved a sunscreen bottle [an outward expression of his emotions] when talking to her and wasn’t actually being aggressive” (P14).

Participants conveyed that nurses should “not take everything as a sign of aggression and pay attention to [the consumers’ lived experience]. Stop ascertaining how they [consumers] should behave [when they are admitted to the hospital]” (P13); “Be open-minded and [respect] that everyone [expresses themselves differently] when they are in a bad mood” (P9). Many participants claimed that being accepted as an individual maintained their self-esteem and reduced the intensity of their negative emotions during hospitalization: “When you are in a hospital facility [away from family and carers], you need help and assistance [to cope with the negative emotions] and having nurses who are understanding and open-minded is probably the best things” (P9), because “when they take time to listen to my story [exploring lived experience], it is easing to my mind [de-escalating the potential for aggression]” (P7).

Category 2: Dialogue to Explore the Reason for the Behaviour

Participants perceived that nurses were often quick to identify and judge consumers as being potentially aggressive when they expressed negative emotions, and this had an impact on nurses’ willingness to interact further with the person. Instead of responding to behaviours such as frustration as an aggression threat, nurses needed to take the opportunity to have a dialogue with the person and ask “What’s troubling you and how can we help you? It is [usually] you need to take this medication and if you don’t do it then we will inject you [give you an intramuscular sedative injection]” (P27). Another participant spoke about his experience:

“They [nurses] don’t communicate properly. They will take an aggressive approach and kind of hands-on grabbing me, dragging me in there [to seclusion], sedating me, and say “here’s the medication and this is what
we are doing because you are aggressive”. I think if they communicate, they would have helped me manage my situation a lot better. My opinion is that if nurses can communicate better rather than just dosing medication when [an individual is expressing intense emotions], they can mitigate the [negative emotions] and the situation would work out a lot better.” (P6)

Participants identified that nurses needed to initiate a dialogue with them to explore the reason for their behaviour before judging the person as being aggressive because “people who get identified as angry when they might just be upset are just going to get angrier and more rebellious if you [nurses] say to them that they look angry” (P26);

“Everyone reacts differently to [being called aggressive], so maybe [the nurse should] sit with them and have a conversation to find out the reason behind the behaviour. Once they [nurses] have the reason, they can help the person [co-producing coping strategies] by asking ‘What to do about it or what would be helpful for you?’” (P12).

There was a consensus among participants that engaging consumers in a dialogue when they were distressed allowed nurses to “validate the person’s feelings” (P5); and “figure out what are the deeper issues that need sorting for the person [during hospitalization]. This will probably support the individual to skip a few steps towards their [personal] recovery” (P10).

**Category 3: Use Positive Communication to Encourage Self-management**

Participants stressed the importance of nurses using positive communication and supporting consumers to self-manage their behaviour. When de-escalating a situation, nurses should “take things slowly and [think about the] words that they [nurses] want to say, carefully. Use positive words to empower the individual to take responsibility for their behaviour and ask the person to try not to [behave aggressively] again” (P8);

“When giving medication, say positive things like, “This is going to help you, this is going to work for you. Let’s give it a go. You can let us know later if this works for you [encourage self-management]. Explain what this medication does to help them feel better, not just stick a needle to sedate them” (P9).

“Be more empathetic and provide positive avenues for the person to take control of their own behaviour and move them toward recovery in mental health” (P18). Participants claimed that when they engaged in therapeutic communication with nurses during the time they were experiencing a personal crisis, they were more encouraged to re-evaluate their own strengths and ability to self-manage their behaviour: “If nurses can use positive reinforcement, they will encourage the person to re-focus on the main issue [that triggered their aggression] and this can motivate them to gain an in-depth understanding of how they can deal with it” (P5); “When they find out the cause of the
aggression, they will move on to identify how it is affecting their life so they may manage it themselves in the future” (P10). Another participant provided this example:

“If [nurses] noticed that the person is aggressive, go talk to them about it instead of telling them what to do as it can be antagonistic because they are in that moment where their mind is racing at one hundred miles an hour. All they are thinking about is I want to hit this, I want to throw this, I want to hit everybody. Sit them and ask them “What is wrong right now, what do you need from us, what can we do to help you, what do you usually use to calm down?” Try various suggestions and it is about getting them to utilise their own strategies [to self-manage] and they will learn about their [own strengths and potentials] on that day.” (P9)

**Category 4: Promote Personal Comfort to De-escalate the Risk for Aggression**

Most participants spoke negatively about having to make adjustments to their familiar lifestyle and daily routines when hospitalized, and how this increased their risk for aggression. They explained that “it is just human nature that [people] tend to get frustrated as they don’t have their own belongings and stuff” (P6); “They cannot get what they want, and this reinforces their feelings of being neglected, so they will do something and try to get it” (P15); “It is quite suppressing [during hospitalization] and I feel like I am living in the moment. Every day is the same and it feels like deja vu” (P3).

While participants accepted the structure and routines of the ward environment, they highlighted how little gestures on the part of nurses could make a positive difference to their experience: “It was raining, and they got me some blanket and gave me a cup of tea which was really nice and reduced my frustration of being hospitalised” (P5); “They [nurses] are reassuring and approachable even when I can be quite demanding. When I am upset, they showed that they are really here to help you and offered me choices: Can I get you a blanket? Can I get you a pillow, a drink, a tea, a coffee?” (P21). One participant provided an example of how increasing her level of comfort reduced her risk for aggression:

“I came in after a traumatic event and was very upset and unwell. I didn’t like [to be hospitalized] so I have been pretty aggressive and being blatantly rude to the nurses. [However] they were really nice, sat me down, got me a tea, and talked to me. They treated me like a human being [promoting level of comfort] instead of just treating me as another number and all these actions made me feel that [nurses] actually do care, so it calmed me down (P11).”

**Category 5: Travel Alongside the Person to Co-produce Strategies for Reducing Aggression**

Participants described their admission to hospital as a personal journey that allowed them to trial clinical and personal strategies to identify ways they could achieve their
recovery goals. There was a consensus that this journey was “just like a trial run, give another shot, give another shot when you get knocked down, keep on going” (P2); “is not overnight” (P14); “it takes a long time” (P15); “[recovery] is hard work, so having nurses [travelling alongside] can help make [consumers] feel like they have to do it alone” (P17). Most participants described recovery as a personal journey to find the strengths that “will come from within themselves” (P2) but the process could potentially increase their risk for aggression if they became “fearful of not knowing what is going to happen” (P5); “impatience [to overcome their life challenges] and probably lost control a little bit [of their self-control]” (P7); because “waiting [for positive outcomes] is the worse feeling especially when [they] are distressed” (P8).

Many participants highlighted that nurses could use this time as an opportunity “to work alongside [consumers] and try to coach them to develop effective strategies to reduce aggression because they are in wiser position [clinically]” (P2), rather than to implement more restrictive practices that could potentially impact on their personal effort to achieve recovery. As one participant stated:

“Personally, I was here because of a particular reason which would be somewhat difficult for nurses to truly understand how I feel. If we [nurses and consumers] all work together [engaging in co-production], we can achieve desirable outcomes and reduce [the risk] for aggression” (P6).

Discussion

This qualitative study contributes evidence on consumers’ perceptions of how nurses can use RFC to reduce aggression in all acute mental health inpatient settings. All participants interviewed displayed positive attitudes toward nurses who used RFC and explained how they believe this model of care can reduce aggression in the clinical environment. Participants highlighted their feelings of being validated and valued as a person as two important components of RFC. Many participants indicated that RFC supported them to achieve personal recovery and mitigated the impact of their lived experience on their risk for being aggressive when hospitalized. This is supported by Antonysamy, who reported that consumers who achieved personal recovery were less likely to display aggression, and the need for nurses to use restrictive practice, such as restraint, during hospitalization was therefore reduced.50

Participants identified that nurses who used RFC explored the consumer’s past and present lived experience during assessment to gain an understanding of the person’s presenting behaviours and potential for aggression. The literature suggests that consumers who displayed aggression when admitted to hospital tend to have a history of physical abuse, psychological trauma, or neglect and social discrimination.35,51,52,53 These negative lived experiences can be reactivated by the interpersonal and environmental factors that exist within all acute mental health inpatient settings and the person’s response to these circumstances may trigger aggression.55 When admitted to the hospital, it will take time for this vulnerable group to build a trusting relationship with
nurses and fully disclose their lived experiences. As they have not previously always be able to voice their concerns, they may continue to choose to utilize aggression to express their needs and preferences unless their interactions with nurses can build their trust to begin to self-manage their behaviours. Therefore, nurses must explore each consumer’s lived experience and assess the intent of the person’s presenting behaviours. When nurses have an increased appreciation of the impact of lived experience on the consumer’s presenting behaviours, they are more likely to talk to the individual, give the person time, and be open and available to help the individual cultivate a sense of safety, trust, and closeness. Lantta et al. stated that nurses who recognized the reason behind the person’s presenting behaviours were able to more accurately interpret the person’s potential for aggression. These nurses were also more confident to use interpersonal and alternative strategies to de-escalate the situation. They were also more sensitive toward the consumer’s individuality and used trauma-informed and person-centred care to help the person feel acknowledged and validated.

In this study, participants highlighted that nurses who used RFC were more likely to implement micro-affirmations, which are little gestures of care, such as offering food, drink, touch, and physical comfort to help consumers to self-regulate their level of risk for aggression. The display of unconditional feelings of warmth and consideration toward these consumers helps them maintain a positive sense of self and address the impact of their negative feelings when admitted to hospital. The feeling of being valued by nurses as a person experiencing a personal or mental health crisis was identified by participants in this study as empowering for building their hope and confidence. This allowed them to take ownership and responsibility of their behaviour, and ultimately their personal and clinical recovery as their mental health improved.

There was a consensus among participants that nurses who used RFC displayed a higher level of therapeutic optimism about consumers’ potential to self-regulate their behaviour. They also conceptualized consumers’ aggression as a learning opportunity and travelled alongside them to help them to identify better ways of expressing their emotions and needs. These nurses chose this strategy rather than the use of restrictive practices. Through co-production, nurses can empower consumers to self-determine or share the decisions about their own care and treatment and increase their awareness of their existing coping mechanisms and resources that they have not yet used. This assists persons to achieve self-growth and actualization of their strengths to overcome the impact of their lived experiences on their behaviour when hospitalized.

**Limitations**

Several limitations are acknowledged in this qualitative study. Firstly, the transferability of findings may only be possible to consumers who have experienced care and treatment in wards that have similar climate, structures, level of staffing, and culture of care delivery. Secondly, the involvement of the treating team to identify people who are
suitable to participate in this study may have potentially introduced a selection bias in determining some participants over the others as shown in their demographic data. However, this was an essential step to ensure that the participants are clinically well enough to understand the nature of this study and their expected involvement, and to make an informed decision to participate. Despite these limitations, the five categories identified in this research were rich and in-depth in the participants’ experience and contributed valuable insight into patients’ perceptions of how nurses can use RFC in all acute mental health inpatient settings to reduce aggression.

Conclusion

The research provides insights into the consumer perspective of potential causes of aggression, and how nurses can use RFC to reduce the risk of aggression in all acute mental health settings. Despite the limitations, the findings contribute to the understanding of the consumer perspective of how nurses can support the personal recovery journey. As RFC is now viewed internationally as the preferred model of care for people with a mental illness, the findings may be tested in future research to translate recovery principles into all mental health settings. The findings can also be incorporated into nursing education and professional development training to increase understanding of consumer perspectives of recovery-focused care in all acute mental health settings, including forensic mental health services.

Acknowledgements

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Understanding the recovery process in psychosis

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KEYWORDS
Recovery, Psychosis, Qualitative Research

Abstract
Conceptualizing recovery in the context of severe and persisting mental health conditions is a complex issue. In recent years, there has been a call to re-focus research from understanding the concept of recovery to improving understanding of the process of recovery. There is a paucity of knowledge about the core processes involved in recovery from psychosis.

Objective: The authors aimed to gain insight into possible processes involved in recovery through analyzing data generated from a large qualitative study investigating employment barriers and support needs of people living with psychosis.

Research Design and Methods: Participants were 137 individuals drawn from six key stakeholder groups. Data obtained from focus groups (14) and individual interviews (34) were analyzed using thematic analysis.

Results: The main recovery processes identified were: learning effective coping strategies; recognizing personal potential; identifying and realizing personal goals; participation in social and occupational roles; positive risk-taking; and reclaiming personal identity.

Discussion: The results of this study have implications for treatment as well as the daily support needs of people recovering from psychosis.

Introduction
Understanding the process of recovery is inextricably linked to the dominant paradigm that exists for understanding mental distress. A radical paradigm shift has occurred in the last decade from a predominantly medical model that focuses on pathology, deficits,

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and ill health towards a more strength-based focus on recovery. Although pharmacological treatments continue to be the mainstay of medical treatment, several non-clinical interventions have been found to be supportive. These include a range of self-management strategies including mindfulness, leisure, recreation, and exercise. Employment has also been found to be an important facilitator of clinical, personal, and social recovery.

To date, the focus of recovery studies has been on understanding the concept of recovery in the context of psychosis. Recovery has been variously conceptualized in terms of clinical, social, personal, and functional outcomes. It has been suggested that, in order to progress the field, there is a need to move beyond consideration of conceptual issues to more of a focus on the processes involved in recovery. Others have proposed recovery involved five recovery processes: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. Although purporting to describe recovery processes, their conceptual framework appears more accurately to describe key components or ingredients of recovery rather than the dynamic processes underlying recovery. Some researchers have proposed models of recovery from psychotic conditions that emphasize stages in recovery. Others, however, have contested the value of such formulations and argued that recovery is not a neat, linear process over time. Therefore, much work remains to be done to clarify conceptual and process issues relating to recovery in psychosis.

Several authors have investigated factors affecting recovery in more severe mental health conditions. For example, one study found that stigma and discrimination negatively impact the process of recovery for people living with mental illness. A multinational qualitative study of twelve individuals with experience of recovery in psychosis identified common themes among participants’ recovery experiences. These included how the person deals with the problems associated with psychosis, the role of material resources, the role of health systems, the role of significant others, and the role of social and cultural factors. A review of the literature highlighted the benefits of physical activity on mental health recovery. Another study affirmed the importance of participation in recreational activities for mental health recovery. The role of psychological factors in recovery has generally been overlooked. These authors argued that possessing insight into a mental health condition does not necessarily promote recovery, and that accepting a diagnosis and prognosis can in some circumstances constitute a barrier to recovery. They developed a model showing that hope and self-esteem, and overcoming self-stigma, are important factors mediating clinical and non-clinical outcomes. Importantly, these researchers found the general unpreparedness for the onset of psychosis, combined with loss of identity and lack of hope, can significantly delay the implementation of effective self-management strategies. It has been proposed that illness identity not only has an important impact on recovery but is also a possible area for psychotherapeutic intervention using approaches such as cognitive behaviour therapy and narrative therapy to change to a more positive identity. They cited evidence for facilitators of recovery among people living with psychosis including identity transformation—from negative self-identity to an
empowered self-identity; use of effective coping strategies, and participation in competitive employment.\textsuperscript{17}

Qualitative studies appear to be well suited to study recovery in psychosis. Given that many researchers and clinicians perceive recovery in psychosis to be a uniquely personal process, in-depth case studies have potential to yield rich insights into the recovery process. For example, a narrative approach was used to investigate the recovery process in psychosis.\textsuperscript{14} Using semi-structured interviews and a narrative approach, the authors identified two divergent recovery typologies: turning toward and turning away. Turning toward involves normalization of voices, attempts to understand the meaning of voices in the context of one’s life, and integration of voices into daily life. Turning away primarily involves distraction and reliance on medication. Relevantly, commonalities were found for both typologies in the recovery processes: acquiring general mental health skills; participation in meaningful activity; connecting with others; a changed response to voices; and developing a positive sense of self.\textsuperscript{14}

The aim of the current study was to investigate the process of recovery in psychosis by searching data from a large qualitative study of people with lived experience of psychosis and of other key stakeholders associated with those with lived experience, to find statements or comments that might provide insights into the dynamic processes involved in recovery. Findings would have implications for interventions that might promote recovery among people living with psychosis.

Research Design and Methods

The data on which the current study is based was drawn from a large qualitative study of employment barriers and support needs in psychosis. The study involved 137 volunteer participants in South East Queensland who were invited to participate in focus groups (14) and individual interviews (34). To ensure a broad range of perspectives was captured in the study, participants were drawn from six key stakeholder groups: clients living with psychosis (25), care-givers (9), health professionals (19), employers (11), employment consultants (27), and community members (46). The sample included participants disclosing a wide range of ages (18-84 years), educational levels (primary school to tertiary level), and occupational categories. Ethical approval for this study was granted by Bond University Higher Research Ethics Committee, reference number RO1091. All participants were given a statement explaining the nature and purpose of the study and were required to provide informed written consent for their data to be used in the research. Focus groups and semi-structured individual interviews were conducted to elicit perceptions regarding barriers to employment and employment support needs of people living with psychosis. The researchers considered these methods would maximize the engagement of participants, facilitate disclosure, and allow the voices of vulnerable participants to be heard.

Focus groups comprizing 3-10 participants drawn from the same stakeholder group were asked to respond to the following two main statements/questions:
Question 1: We know that many people who have been diagnosed with schizophrenia or bipolar disorder would like to work in regular paid employment. We also know that the employment rate of people with these conditions is significantly lower than the general population. Why do you think this is the case?

Question 2: What do you think would need to change in order to improve employment outcomes for people who have been diagnosed with schizophrenia or bipolar disorder?

Focus groups were of approximately one’s hour duration, with approximately thirty minutes allocated to discussing each question.

In-depth individual interviews were conducted with participants who were unable to attend focus groups and/or whose life experiences were deemed, either by the researchers or by the participants in the study, as likely to provide a relevant source of data. Semi-structured interview schedules were developed which included the two main questions posed to focus group participants as well as a selection of open-ended questions tailored to the expertise and experience of the specific stakeholder group. A responsive interviewing style was used. In responsive interviewing, the interviewer listens deeply to interviewees and flexibly adapts the interview questions to elicit in-depth information and follow up on new insights. Interviews were of approximately one hour’s duration and were recorded using two digital voice recorders. Recordings were transcribed verbatim and the transcripts were imported into NVivo 10 for analysis. The data were analyzed using thematic analysis, a qualitative analytic method. Another paper provided more information concerning the interview questions and procedures.

For purposes of the current study, all transcripts were thoroughly searched for all references pertaining to recovery from psychosis, and these were coded to a node labelled recovery. The contents of this node were subsequently reviewed and arranged into sub-nodes pertaining to the concept of recovery, recovery process, and barriers to recovery. Although references related to various aspects of recovery emerged from the data, only results on the process of recovery are presented in this paper.

Results

A thorough search of the transcripts revealed 106 references to recovery from 19 sources. Seventeen references obtained from 10 sources alluded to the process of recovery in psychosis. Recovery was conceptualized by participants in terms of a personal journey. For example, one client participant said:

"...it’s actually a journey that you’re going through now and stick with it, you know, persevere ’cause at the end of the day if you’re just starting out...well I’ve had a pretty amazing life meeting the people I have for my mental illness."
The Process of Recovery

Participants perceived six key processes involved in recovery, namely, self-care, recognizing personal potential, personal aspirations, participation in social and occupational roles, positive risk-taking, and restoring personal identity:

Recovery is about self-care

This theme incorporated references to the role of self-management in facilitating recovery. Participants pointed to the need for individuals to be proactive in maintaining their own mental well-being. A client living with bipolar disorder emphasized the need to take personal responsibility for self-care:

"I know a lot of bipolar people would rather just sit there and say, 'Ah fuck it, it's the doctor's problem. They're the ones that made me this way.' Realistically no one's to blame but you are to blame if you don't get off your arse and help yourself...and you don't go see a doctor and try and sort out medication and if that doctor is not working for you shit go find another one, there's plenty out there and they're all there to help. It's taken me ten, fifteen years to find the right doctor...Now [that] I have I'm not letting them go!"

Recovery is about recognising personal potential

This theme captured references to looking beyond a person’s mental health condition to recognize their unique human potential. A psychologist pointed out the importance of recognizing individual potential: "I think better assessment and multi-disciplinary assessment would be useful so that it’s not a narrow view of illness but a broader view that brings more of the idea around potential that people have rather than the actual present condition because recovery is a lot about potential." Responses indicated that recovery is about identifying, claiming, and developing personal strengths. This view is reflected in the following client quotes: "...as long as I’m fit, I can pick up timber posts and that...with my hand you know... I’m pretty fit. If you put a bloke out on a property, on a station, there’s farm work. You can pick up timber posts and there’s good money in it..." "I'm still capable of working. You know there might be something wrong with my mind, but there’s nothing wrong with my body...so I’m still capable of working..."

Recovery is about personal aspirations

This theme incorporated references to identifying and fulfilling personal goals and aspirations. Dreams and aspirations were deemed important to recovery. This perspective is illustrated in the following quote by a psychologist:

"Well it depends on what you're talking about when you say recovery. It’s not necessarily a state that is very concrete, and
there are some people for whom going back to work is not realistic and for them recovery is more around them being able to live a fulfilling life in other ways...There are various contributions they can make. An obvious one is that they can be available as a companion or a friend of someone else with a mental illness like a buddy, support person. It really depends on the individual. They can be more active in their family. It really depends on what the person themselves considers to be a fulfilling life.... what they see as potentially meaningful and purposeful activity for their life."

**Recovery is about participation in social and occupational roles**

This theme comprised references to the importance of social and occupational roles in the recovery process. In addition to the pursuit of personal hobbies and interests, integration into socially valued roles such as study and employment were seen to be conducive to recovery. A carer commented, "I think there needs to be a whole different flexibility away from, you know, it has to be a job. It's really how do you get people to flourish in, not just mental health, but in an interactive way...”.

Meaning in life was also identified as an important component of recovery. A client participant reported, “…by giving new members [of clubhouse] tours, it does give you a sense of purpose...gives you a sense of meaning to wake up.” Importantly, meaningful activity was perceived to provide distraction from symptoms and alleviate boredom and social isolation which leads to rumination: A medical officer recalled, "I used to have a patient who ran their own [business] in xxx, did so for years, and you wouldn’t know...she had voices most of the day, yeah, worse at night when she got home...because she wasn’t distracted any more...” A psychiatrist affirmed, “...they will tell me, you know, doctor, when I work those voices are less. I get distracted from the voices, that’s why I like my work.” A client participant asserted "...the other thing that comes into play is the more time that I have by myself or the less interaction that I have with other people, the more I end up thinking about the past or thinking about things too much".

**Recovery is about positive risk-taking**

This theme incorporated references to measured risk-taking, which was seen as part of the recovery process. Measured risk-taking was seen to be part of the recovery process. An occupational therapist explained, “An important aspect of recovery involves challenging personal comfort zones. But not too much...” Participants questioned whether some health professionals and other key stakeholders provided sufficient encouragement for people to work and achieve their potential. Peer workers suggested that encouragement to take positive risks is necessary for recovery: "...it’s just pushing them, you know, to take that risk and that’s what recovery is about... just do an extra shift and see how you go and that they’re capable of it but sometimes they don’t have
that confidence." A client participant said: "I push myself to stay in there [work] 'cause I know normalcy is what will make me better, whereas a lot of other bipolar people will just go and hide under a rock and just say, 'Let's be done with it...I can't do this'"

**Recovery is about restoring personal identity**

This theme incorporated references to the need to re-assert one’s personal identity over an illness identity. Participants voiced the importance of understanding and insight into the relationship between their identity and their symptoms. A peer worker explained:

"The goal of recovery to me is to actually take that mental illness and what we say is put it on a leash (laughs) and put it in the background. It's in the background of your life rather than having it as your identity, which happens to a lot of people, that it's in the forefront of their mind, their lives, and it's like their whole identity is schizophrenia or bipolar. To me, recovery is when you make that smaller and smaller and smaller till....like honestly I forget about it, all the time, that I even had a mental illness....It's like it goes completely away and you're so busy living your life that you forget that you even have a mental illness".

A peer support worker pointed out the impact of social stigma on self-identity:

"With mental illness, they take the illness and make it the whole person. They don't usually do that with a physical illness. They don't usually take someone who's got some small physical illness that they're treated for and suddenly their whole life is about that [the illness] ...but the stigma makes people think that if you’ve got a mental illness that's all you are...."

In pursuit of socially recognized and valued roles, individuals gain and/or restructure a sense of personal identity. The process of building a sense of identity was illustrated in this client quote:

“...when someone [says to you] What do you do? [and you reply] 'I don’t work' people really look down on you...but when you say I work at [retail food store] part-time...you’re just like everyone else. You know you’ve got an identity or whatever it is.”

**Discussion**

The aim of this study was to explore participants' perceptions of the process of recovery. A thematic analysis of the data revealed that the process of recovery involves at least six key processes: empowering self-care through developing coping strategies; recognizing personal potential; identifying and realizing personal aspirations;
participation in social and occupational roles; positive risk-taking; and restoring personal identity. There was support in this study for Leamy et al.’s view that recovery is a journey, and the framework for recovery they proposed which highlighted the importance of connectedness, hope and optimism about the future, identity, meaning in life, and empowerment.12 Our study went further to suggest the importance of positive risk-taking in recovery. These insights have practical implications for the way in which individuals are supported on the recovery journey. It could also be argued that interventions to facilitate the six recovery processes identified in our study would promote recovery by generating connectedness, hope, self-identity, hope, and optimism.

Our finding of the importance of recognizing and realizing personal potential aligns well with the strengths-based approach.1 In keeping with other studies that have emphasized the central importance of illness identity to recovery, our study found that establishment of a personal identity was an important recovery process.17 Positive sense of self has been identified as central to the recovery process.14 Our study extends this finding by spelling out how this might be achieved, for example, through overcoming self-stigmatization, recognition of personal potential, and support to develop and attain personal goals. Consistent with a study by Yanos et al., our study identified in the common themes of participants that learning effective coping strategies is an important aspect of the recovery process.17 This finding is consistent with De Jager et al., who found more specifically that a changed relationship to voices (that is, more effective coping) is an essential part of the recovery process.14 Similar to De Jager et al., who identified meaningful activity and connecting with others as an important recovery process, participants in our study highlighted the importance of participation in social and occupational roles in the recovery process. There was also evidence from our study to support the finding of Yanos et al. that participation in work can alleviate symptoms.17 Importantly our study highlights some other areas that have not received as much attention in the research literature e.g., the need for positive risk taking in what is essentially a risk-averse mental health system. This is a unique finding in this research and points to the need to challenge mental health systems that are typically risk-averse.

A limitation of this study is that the findings emerged from a study of employment barriers and support needs of people living with psychosis. Future studies, including case studies, that are more explicitly designed to elicit information about the key processes, barriers, and facilitators of recovery in psychosis would be helpful in progressing this important area of research.

The findings suggest that recovery outcomes for people living with psychosis may be facilitated through psycho-social interventions to support improved self-management, recognize and actualize personal potential, restore personal identity and manage the effects of stigma, and facilitate engagement in valued social and occupational roles. The findings suggest a need for more psychological interventions to promote recovery. These might include cognitive-behavioural therapies to improve self-management of symptoms;21 mindfulness interventions to enable people to develop a different
relationship with their symptoms; interventions to address self-identity issues and self-stigmatisation; and interventions such as motivational interviewing to promote effective engagement of people with psychosis in valued social and occupational roles. Furthermore, the findings on the importance of self-identity issues in recovery also suggest the need for broader social initiatives to reduce social stigma and discrimination, increase hope, and provide opportunities for social and vocational inclusion.

Identifying the psychosocial processes underlying recovery from psychosis is an important area of research. This study identified six processes which were perceived by participants to be key in recovery from psychosis: self-care, identifying personal aspirations, recognizing personal potential, restoring self-identity, positive risk-taking, and participation in social and occupational roles. These findings have important implications for practice in the field of mental health recovery. Through identifying key processes, the study has improved understanding of the dynamic processes involved in recovery and pointed to several possible areas of psychosocial intervention, any one of which has potential to promote recovery of people living with psychosis.

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Not Guilty by Reason of Insanity and the Recovery Paradigm: Are They Compatible?

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KEYWORDS

Recovery, Medical Model, Insanity Defence

Some individuals will be placed within forensic hospitals after being found not guilty of having committed a criminal offence by reason of insanity (NGRI). This defence removes responsibility for a criminal act and assigns it to the mental illness. This negation of responsibility is at odds with the key tenets of the recovery approach, which prioritizes the empowerment of individuals to self-determine their actions. An over-application of empowerment and self-determination for persons with severe mental illness can unfairly attribute guilt in such cases.

A medical model (MM) understanding of mental illness instead treats mental illness as a discrete entity subjectable to diagnosis and treatment. Emerging neuroscientific evidence supports this and is being adopted in criminal cases—including NGRI defences. Through an MM approach, the criminal justice system can focus on preventing future harms by providing care and forgo attributing blame unfairly.

However, fully embracing the MM in NGRI cases is problematic. A designation of NGRI is highly stigmatizing and counterproductive when considered within the recovery approach. This paper argues that a subjective mental state test that permits non-culpability for severely mentally unwell individuals and makes distinct the criminal act from the mental illness is needed.

Introduction

Forensic psychiatry offers treatment to mentally disordered offenders. Some individuals within forensic settings will be placed there after being found not guilty of having committed a criminal offence by reason of insanity (NGRI). In these cases, the criminal justice system separates and makes distinct the mental illness experienced by the individual from the individual’s self. This precludes individual liability for criminal
wrongdoing and assigns it to the mental illness. Doing this justifies from a legal and paternalistic perspective the imposition of an order for treatment in the place of a prison sentence or other punitive measure. In short, NGRI is society excusing the person and attributing cause to the mental illness.

This assumes a side in a contentious philosophical debate in the field of mental health care—whether a mental illness, so called, is an intrinsic part of the individual living with it or a discrete and separate entity that can be diagnosed and treated. These contradictory positions as to the ontological nature of mental illness can best be illustrated through an exploration of two approaches to the provision of forensic mental health care and how they consider individuals' responsibility and self-determination.

The first of these, the recovery paradigm, assumes that mental illness is part of the individual, something that can be lived with when not exceedingly overbearing or inhibitive. It proposes that individuals with mental illness can take responsibility for, and, through empowerment, self-determine their actions. The second is the medical model. This treats mental health concerns as if they are biological maladies and foreign entities. It aims to identify symptoms and diagnose and prescribe suitable medication to subsequently treat a mental illness that is separate from the self and distinct from the self-determination of the individual.

**Aims of the Paper**

This paper seeks to discuss the compatibility of the recovery approach and medical model in forensic psychiatric care with regard to individuals considered NGRI. The fundamental elements of the recovery paradigm and the medical model are described. This is followed by an assessment of criminal responsibility and mental illness in criminal law courts. It will be argued that the medical model and the recovery paradigm are incompatible when attributing levels of responsibility and self-determination to individuals found NGRI, as a full application of the recovery paradigm's principles would over-prescribe these concepts.

This contention is furthered by neuroscientific evidence and courts’ contemplation of the NGRI defence in individuals with mental illness who arrive on criminal charges. In light of this, an alternative approach to the legal formulation of the NGRI defence as proposed by Slobogin, in line with the UN Convention on the Rights of Persons with Disabilities (CRPD), is provided. It is proposed that this formulation is more convincingly compatible with both the recovery paradigm and the medical model. This approach would make distinct mental illness and crime whilst reducing stigma and not holding people responsible in circumstances in which it is not fair to do so.

This paper therefore hopes to further discussions concerning the attribution of responsibility to individuals’ excused culpability following the commission of a criminal act in light of absent responsibility. This debate is salient given contemporary efforts to implement the CRPD internationally and furthers discussion of the recovery model's applicability to forensic settings.
Recovery Approach

The recovery movement has its roots in various social, political, and economic reforms of the 1950s and 60s. During this period, mental health care in the West underwent a paradigm shift. No longer was it considered that the treatment of individuals with serious mental illnesses was best provided in large psychiatric asylums cut off from society. Instead, there were movements to promote patient autonomy and provide care as close to the individual’s home setting as possible, and in the least restrictive manner.

This aimed to help individuals reintegrate or stay integrated within their social and economic circles and reduce the stigmatizing ‘otherness’ of those living with mental illness. These reforms built on research that found large asylums were at times harmful and advances in psychopharmacological medication that made psychotic symptoms more self-manageable. This occurred at the same time that broader human rights movements aimed to curtail stigma and exclusion associated with an individual’s sexual orientation and civil status. The recovery approach’s main proponents come from the psychosocial rehabilitation and consumer movements who wanted an approach to the treatment of mental health issues that explored a patient’s entire life circumstances and not simply their medical diagnosis.

Advocates of the recovery approach dedicate much time trying to conceptualize and operationalize the concept. This is in large part due to the increased importance given to recovery approach in countries’ national mental health policies. Myriad definitions exist, but recovery is typically defined as an inherently subjective experience. It may be considered a journey or an end-point. Anthony defines recovery as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles... and a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness.”

Several reviews have attempted to describe and operationalize recovery. Leamy et al. conducted a systematic review and narrative synthesis. The authors found that recovery comprised five key aspects: Connectedness, Hope and optimism for the future, Identity, Meaning in life, and Empowerment (CHIME). Jacobson & Greenley proposed that there are internal and external facilitators in the process of recovery. Internal factors mirror the CHIME acronym including: hope, optimism about the future, and control over one’s life. External factors include the human rights conditions facilitating treatment, a positive culture of healing, empathy, trust, compassion, and respect from healthcare providers. Ultimately, recovery approaches aim toward achieving a sense of purpose and mastery over one’s life, rather than the elimination of psychiatric diagnoses.

Fundamental to the recovery process are notions of responsibility and self-determination. Conceptualizations and experiences of recovery emphasize that individuals should play a role in planning their care and daily life, and take responsibility for their actions. This helps to reduce the stigma of those with mental illness as being incapable and lacking control. This sentiment is reflected in the UN CRPD. Article 12 of the document stipulates that “states shall [recognize] that persons with disabilities enjoy
legal capacity on an equal basis with others in all aspects of life." The document precludes deprivation of liberty on the sole grounds of mental illness.\textsuperscript{17}

Accompanying documentation to the Convention asserts that “recognition of the legal capacity of persons with disabilities requires abolishing defences based on the negation of criminal responsibility because of the existence of a mental or intellectual disability.”\textsuperscript{18} This embodies the sentiment explicit in the consumer rights movement, and is concomitant to the recovery approach’s contestation that individuals with mental illnesses are self-determining, autonomous actors capable of making life decisions and assuming responsibility for these.

\textbf{Medical Model} \\

Conversely, the medical model aims to understand the causes, symptoms, and progressions of illnesses in the body through the application of the scientific method.\textsuperscript{19} The scientific method adopts the methodical and transparent collection and collation of observations and data about the world.\textsuperscript{20} The medical model can thus be described as the “[s]cientific process of observation, description and differentiation, which moves from [recognizing] and treating symptoms to identifying disease aetiologies and developing specific treatments.”\textsuperscript{21} It is the accumulation of such knowledge that informs the day-to-day practices of medical professionals, particularly doctors and psychiatrists.

The medical model is at times criticized for being paternalistic, inhumane, and reductionist.\textsuperscript{22} This is in part because of the historical importance the medical profession has given to understanding the biological aetiologies of illness. Practitioners or researchers embracing the medical model may appear to look through the individual, choosing to concern themselves with the endophenotypic over the phenomenal or emotional.\textsuperscript{6} The medical model has since turned towards a biopsychosocial approach in order to better understand the causes and prognoses of illnesses.\textsuperscript{23} However, the epistemology of the medical model remains the same, and the scientific method is the most prominent method used to study and treat ill-health.

In mental health care, the influence of the medical model can be seen in the paradigmatic Kraepelinian classification systems of the DSM\textsuperscript{24} and ICD\textsuperscript{25} manuals. Mental illnesses are categorized into discrete, diagnosable entities. Each diagnosis has a set of symptoms and expected developmental stages. The utility of this system allows research to be conducted on mental illnesses across multiple settings, aiding in the development of effective medications. Patients with similar diagnoses can be placed together to encourage peer support and shared experience. Greater transparency as to how diagnoses were arrived at can be demonstrated. Proponents also assert that the medical model is evidenced-based and therefore value-free.\textsuperscript{19}

However, detractors argue that these classifications are operationalized in a way that have little empirical weight; disparate reliability; cannot suitably capture comorbidities; and further that many diagnoses do not traverse cultural boundaries.\textsuperscript{22} Patients also report the negative effects of stigmatizing or pathologizing diagnostic labels.\textsuperscript{26}
Mental illnesses understood through the lens of the medical model are entities that can be studied and designated. They can be ‘treated’ with medication, which implies that on an endophenotypic level, mental illnesses are to a certain extent predictable or determinable, operating outside the determination of the individual with the mental illness.

**Mental Illness and Responsibility for Criminal Acts**

Criminal responsibility traditionally requires actus reus and mens rea. The former is the criminal ‘act’ itself and the latter the ‘intention’ to commit the crime. In common law jurisdictions such as England and Wales, the classic legal formulation to assess mens rea is the McNaghten construction. This asks whether

"at the time of committing the crime the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know what he was doing was wrong."

Where insufficient mens rea is established, an individual might be considered not guilty by reason of insanity.

Legal systems differ in their designation of individuals with mental illnesses following the commission of a criminal act. In England and Wales, NGRI defences are rare and typically used only in cases concerning murder. Most forensic patients are admitted following a prison transfer or conviction for a criminal act and being found to be suffering from a mental illness “of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment” at the time of sentencing (Section 37 Mental Health Act, 1983 (as amended)). Ultimately, individuals found NGRI are not convicted of an offence and thus are not punished, but rather given involuntary treatment in a secure setting.

The preclusion of explicit punishment in this instance falls within what Slobogin calls the preventive model of liberty deprivation. This model presupposes that individuals may cause future harm to themselves or others, and the state is not concerned with ascribing blame for previous harms. In contrast to this, a retributive model of liberty deprivation holds to account and seeks to punish individuals considered responsible for committing harm to others. This approach assumes that individuals who commit criminal acts do so in a way that reflects principles of autonomy and self-determination—long-standing principles in the administration of criminal justice. Thus, according to these models, individuals found NGRI are deprived of their liberty for future harm prevention and not punishment for autonomous behaviour.

This presents the recovery paradigm with a dilemma. One of the key tenets of recovery approach is the ability of individuals with a mental illness to self-determine and be responsible for their actions. This is to aid empowerment in recovery and reduce the stigma of incapacity and mental illness—sentiments reflected in the UN CRPD. However, some individuals experience debilitating mental illnesses against which it is hard and arguably unethical to hold them accountable for particular actions. This leaves
one asking whether a strict application of the recovery paradigm to these individuals would advocate removing the NGRI defence, thereby resorting to a retributive model of liberty deprivation or assigning responsibility in circumstance to which it may not be fair or accurate to do so.

**Neuroscientific Evidence and Criminality**

Given that the medical model proposes that mental illnesses are discrete entities distinct from the individual, it purportedly provides a reasonable empirical justification for the NGRI defence. Research conducted within the neurological sciences questions the extent to which human behaviour and emotion may be fully self-determined.30, 31

Neuroscientific research using fMRI, MRI, and EMR techniques suggest that individuals scoring highly on measures of psychopathy demonstrate paralimbic system dysfunction in the brain.32 Research using fMRI techniques has also shown that individuals diagnosed with psychopathy that have committed a criminal offence exhibit abnormal functioning in specific areas of the brain when distinguishing abstract from concrete linguistic stimuli.33

Anderson and colleagues found that individuals receiving injuries to the prefrontal cortex region of the brain at an early age were likely to later develop behavioural deficits; struggle to appreciate future consequences of decisions, including the prospect of punishment; and present defective moral and social reasoning.34 These behavioural deficits are diagnostic criteria for psychopathy and reflect the content of the Psychopathy Checklist-Revised (PCL-R).35 These deficits limit the extent to which psychopathic individuals can employ theory-of-mind techniques such as empathy and placing oneself in another’s shoes. These traits play an important role in conforming to socially accepted and non-criminal behaviour.

The neurobiology of psychosis and violence has been explored with similar techniques. Studies are in their infancy and results are mixed; however, there are indications that differences exist for the functioning of certain areas of the brain between schizophrenic patients with and without a history of aggression.36 Indeed, in a review of current neurobiological research on schizophrenia and aggression, Soyka notes:

> “Several findings seem to indicate that in schizophrenia patients with aggression or persistent violence, certain brain functions or areas—in particular the prefrontal and frontal cortex—may be more severely impaired than in schizophrenia patients without aggression or violence.”37

Dysfunction of the prefrontal cortex has been associated with violence and antisocial behaviour.

This brief summary suggests that there may be dysfunctions in the brain that increase the likelihood for some mentally ill persons to demonstrate behaviours deemed antisocial or criminal.
These examples highlight a medical model approach to the aetiology of psychopathy and psychosis. They suggest that certain criminogenic behaviours and emotional regulation may be associated with dysfunctions in the brain. Such studies are being used in criminal cases to mitigate individuals’ liability for criminal behaviour. It should be noted that evidence linking biological and neurological traits with criminality is mixed, its use in courts limited. More research is needed. However, research is slowly generating evidence to suggest that responsibility for one’s actions can be diminished or negated by mental illness or defect—a position supporting the NGRI defence. This is not compatible with the emphasis the recovery paradigm places upon individual self-determination and empowerment.

Reconciling NGRI and the Recovery Paradigm: A New Approach

It would seem that to apply all the principles of the recovery model to all individuals all the time would be unfair and unhelpful. The recovery paradigm’s key tenets of self-determination, responsibility, and empowerment are difficult to reconcile with the above studies and the NGRI defence.

The medical model addresses self-determination and responsibility differently. This approach can better facilitate care for mentally disordered offenders. By mitigating or removing responsibility for one’s action based on the presence of a mental illness, the criminal justice system can forgo a retributive model or avoid attributing blame unfairly. Instead, it can focus on preventing future harms by providing care.

Any finding of NGRI and subsequent treatment order is provided in the place of a punitive measure or unfair attribution of blame. This coincidentally serves several of the aims of the recovery approach. Individuals found NGRI can be placed within secure settings. These are ostensibly non-punitive environments that can provide a culture of care not possible in prison settings; permit periods of leave intended to maintain ties to the community; administer suitable medications; and will not condemn the individual as a fully accountable criminal wrongdoer. This all seems positive.

However, the NGRI defence still carries significant stigma. This is a flaw of the medical model approach. Slobogin has proposed a formulation of the NGRI defence in line with the UN CRPD stipulation that “...persons with disabilities shall enjoy legal capacity on an equal basis with others in all aspects of life.” His approach removes mention of mental illness from the defence and replaces it with a subjective mens rea criteria that can be applied to both individuals with or without mental illness.

In this construction, an individual would be excused responsibility from an offence if they

“(a) lacked the subjective mental state for the conduct, circumstance, or result element of the crime; (b) believed circumstances existed that, if true, would have justified the offense; or (c) believed circumstances existed that, if true, would have amounted to duress; provided that he or she did not cause any of these mental states.”

2
This reformulation would still permit a mitigation of responsibility for criminal acts in line with the prevailing medical model approach. Where an individual lacked the subjective mental state, they would not be held culpable. However, the assessment of culpability is not contingent on the presence of a mental illness per se. It would accommodate the recovery paradigm’s emphasis on reducing stigma by making distinct the nexus between a mental illness—which is evolving, fluctuating, and not inherently criminogenic—and the criminal act.

Such a test would be applicable for individuals living with a mental illness and those not. It assumes that individuals with mental illness are capable of self-determination 'generally,' but in this particular instance lacked the subjective mental state. Individuals that present at court with a mental illness at the time of sentencing could still receive a treatment order, but the crucial nexus between mental illness and crime is lost; instead, the nexus between subjective mental state and crime is adjudicated. Individuals excused of culpability in this way can then engage in any needed treatment framed within the recovery paradigm.4,16

The principles of autonomy, empowerment, and self-determination can consistently be embraced by these individuals in their recovery. This is because these concepts are ascribed to individuals living with a mental illness that has not been denied when found NGRI due to that mental illness. Instead, responsibility and autonomy are negated only for the purpose of assessing culpability at a single moment.

**Conclusion**

This paper has argued that the forensic psychiatric care system highlights an incompatibility between the medical model and the recovery paradigm. This incompatibility considers the extent agency is attributed to individuals with mental illness and the degree to which they ought to be held responsible for their actions.

The criminal justice system, tasked with establishing culpability for wrongdoing, does mitigate or preclude responsibility for certain individuals’ actions, sometimes through the NGRI defence. This draws on principles taken from the medical model’s approach to understanding the aetiology, symptoms, and prognosis of discrete, classifiable mental illnesses. This approach separates to a degree the mental illness from the individual and in doing so ascribes blameworthiness to it.

This runs counter to the recovery paradigm, which proposes that individuals can live alongside their mental illness, take responsibility for their actions, and, through empowerment, are capable of self-determination. In cases of criminal conduct connected to severe mental illness, these concepts are stretched. The medical model’s removal of the mental illness from the self arguably better facilitates treatment for these individuals and precludes assigning guilt where it does not morally belong.

It is important to reconcile current NGRI defences with the recovery paradigm. Thinking critically about how to ascribe empowerment and self-determination to individuals found not responsible for their actions is a necessary step toward this. Slobogin’s contribution removes mental illness from assessments of responsibility and provides for a subjective
mental state test.\textsuperscript{2} Such an approach reduces the stigma of mental illness by making distinct culpability for criminal acts and mental illness. It avoids situations wherein individuals that ought not to be held culpable for their actions are held fully responsible—a possible proposition if all tenets of the recovery paradigm are strictly implemented.

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Toward a Shared Vision for Mental Health and Addiction Recovery and Well-Being: An Integrated Two-Continuum Model

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Introduction

Recovery is a key concept driving system transformation in both the addiction and mental health sectors, with shared roots in advocacy and a shared focus on hope in the face of stigma, self-determination, and meaningful lives. Nevertheless, while cure is generally not thought to be necessary for mental health recovery, addiction recovery is generally thought to start with abstinence. To the extent that cure, as the cessation of mental illness, is analogous with abstinence, as the cessation of addiction, this difference creates a disconnect between how recovery is conceptualized in the two sectors. While this difference has grown narrower with the growing integration of harm reduction into the addictions field and with the growing integration of the mental health and addictions sectors more broadly, the disconnect remains strong enough to undermine coherence at the policy level. Mental health policies use recovery in one way and addiction policies use it in another, or the term is used interchangeably without acknowledging important conceptual differences.

The lack of coherence at the policy level is particularly problematic given the central place of recovery in articulating and driving the vision for transformation in both the mental health and addictions sectors. At the service delivery level, conceptual confusion regarding recovery exacerbates the fragmentation between mental health and addictions services that is already concerning, particularly in light of shared risk and protective factors for mental health and substance use problems and high rates of concurrent disorders. Among Canadians with mental health or substance use disorders an estimated 15–20% have both concurrently.
This paper examines the potential for harm reduction, as an alternative to an abstinence-only model of addiction recovery, to bridge the conceptual differences with mental health recovery. Further, this paper considers whether integrating substance use and harm reduction into a two-continuum model of recovery and well-being that was developed in the mental health sector can bridge the conceptual differences between addiction recovery and mental health recovery, and in so doing clear a path toward a shared vision for recovery and well-being.

**Concept Analysis**

This qualitative synthesis draws on concept analysis to compare the use and defining attributes of mental health recovery, addictions recovery, and harm reduction. In health research (particularly in nursing scholarship), concept analysis is used to develop clear operational definitions of vague or abstract concepts with a view to improving communication and diagnostic assessments. Concept analysis has its roots in conceptual analysis, which has been the dominant method in philosophical inquiry since the days of Aristotle and Plato. In the philosophical tradition, conceptual analysis includes identifying the necessary and sufficient conditions associated with a particular concept, and then testing these against illustrative examples (referred to as cases) and counterexamples. Similar to conceptual analysis, concept analysis involves a series of steps to first clarify the attributes of a concept and then test these through the development of cases and counter-cases. Where conceptual analysis has been criticized for relying on the intuition of ‘armchair philosophers’, concept analysis is more decidedly empirical in that it draws on the literature for its assessment of the uses and attributes of concepts.

As a concept analysis, this paper first compares the use and attributes of mental health recovery and addiction recovery, drawing on empirical examples from policy documents, other grey literature, and academic sources. An integrated conceptual model is then proposed based on the results of this comparison. This proposed model will be further refined through interviews and focus groups in the second phase of a broader qualitative research project.

**Addiction Recovery: Core Attributes**

The recovery movement in the addiction field is closely associated with the Alcoholics Anonymous (AA) recovery program that originated in the United States in 1935. While AA views alcoholism as a disease rather than a moral failing, it shares a commitment to abstinence with the earlier temperance movement. AA’s self-stated primary purpose is "to stay sober and help other alcoholics to achieve sobriety". The journey of recovery begins with the last drink; day-by-day abstinence is marked by sobriety tokens or chips etched with the words ‘unity,’ ‘service,’ and ‘recovery’. Today AA is a movement with meetings held in most communities and a global reach. As such, AA has had a powerful influence over how recovery is conceptualized in the addictions sector.
In the 1990s, a new recovery movement emerged that shifted AA’s disease-based conceptualization of recovery toward one based around hope and resilience, while still maintaining AA’s focus on lived experience and peer support.\textsuperscript{12} Spurred in part by the growth of the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Recovery Month, people who once defined themselves around Alcoholics Anonymous (AA) increasingly define themselves as ‘people in long-term recovery’ and embrace recovery’s message of hope in the face of stigma.

While this focus on long-term recovery has a softer approach to abstinence than AA, abstinence is still viewed as a core attribute. For example, Faces and Voices of Recovery based out of Washington, DC is the leading organization in this new movement, and describes itself as follows:

“We are the moms and dads, sons and daughters, brothers and sisters, husbands and wives, and friends of people regaining their health and lives through freedom from addiction. By organizing and speaking out together, we support and give hope to individuals who are still struggling with addiction and to those who have found the power of long-term recovery”.\textsuperscript{13}

Another example can be found in a survey undertaken by the Canadian Centre on Substance Use and Addiction.\textsuperscript{14} When asked for their personal definitions of recovery, 52% of respondents included the concept of abstinence with only 14% including the next most commonly reported concept, quality of life. Further, 96% of respondents agreed with a definition of recovery that introduces some flexibility but still leads with abstinence, as follows: “In addition to abstinence or stopping uncontrolled substance use, recovery implies improved health, function, and quality of life”.\textsuperscript{14}

As can be seen from the above examples, the addiction recovery movement increasingly reaches beyond abstinence to focus on broader factors such as relationships, housing, and work as core components of a meaningful life.\textsuperscript{15, 16} In the addictions sector, these internal and external resources are sometimes referred to as recovery capital\textsuperscript{17}. In keeping with its origins in the sociological theory of social capital, recovery capital places particular emphasis on the role of transformed social networks to replace those associated with substance use, as well as on resources within the broader community.\textsuperscript{18} Responses to substance use problems, whether at the individual or community level, need to take both the amount of recovery capital and the severity of the problems into account.

There are also calls of varying degrees of strength within the addictions sector for a less abstinence-focused definition of recovery. The emerging focus on long-term recovery has increased attention to evidence showing that the risk of relapse is highest early on in the recovery journey then diminishes over time.\textsuperscript{16} While still defining recovery in relation to abstinence, this evidence does acknowledge that relapse is a common
experience. William White, a leader in the addiction recovery movement, has proposed a definition of recovery that focuses on the resolution of substance use problems rather than abstinence per se, including the notion of partial or moderated recovery.\textsuperscript{1, 19} Also invoking evidence, White argues,

"If abstinence is a defining element of recovery, then a moderated resolution of alcohol and other drug problems would, by definition, not constitute recovery. The problem is that such a definition flies in the face of a growing body of evidence that such moderated outcomes are possible for many people with mild-to-moderate substance-related problems as well as for a much smaller percentage of people with substance dependence".\textsuperscript{19}

A more radical departure from abstinence-based definitions of recovery stems from harm reduction advocates. In contrast to abstinence-based approaches, harm reduction is generally used to describe “those policies, programs and interventions that seek to reduce or minimize the adverse health and social consequences of drug use without requiring an individual to discontinue drug use”.\textsuperscript{20} While harm reduction is often associated with responses to drug use such as supervised injection sites and needle exchanges, it is also used in relation to alcohol through initiatives such as safer drinking guidelines and managed alcohol programs.

To the extent that recovery is defined around abstinence, harm reduction and recovery are fundamentally incompatible. This tension is visible in the addictions treatment centres, which sometimes acknowledge harm reduction approaches even as they largely hew to abstinence-based approaches rooted in AA’s 12-step program. For example, one treatment centre based in the United States makes the following argument:

“There may be value in combining the best principles of harm reduction and abstinence. Most recently, some researchers are looking at how harm reduction can be used to work toward abstinence ... [W]e take an abstinence-based approach, but we also recognize the individuality of our clients and work together to develop treatment plans that will work for them. We believe that a life free from dependence and addiction has the most potential for happiness and health.”\textsuperscript{21}

To the extent that a more flexible definition of recovery is used, harm reduction and recovery share many attributes. Like recovery, harm reduction is an advocacy movement with a strong focus on self-determination, lived experience, and rights, as can be seen in the position taken by Harm Reduction International: “Harm reduction is grounded in justice and human rights—it focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop
using drugs as a precondition of support”. There are emerging calls for harm reduction and recovery to be better integrated. For example, Gallagher et al. issued the following challenge:

“We challenge the agency-driven dichotomy of being either a harm-reduction or an abstinence-based program. Recovery is best understood on a spectrum and should be defined by the individuals we serve, not the projection of professional values or agency agendas of what they think one’s recovery should look like”.

At the service delivery level, recovery coaches are an example of integration between harm reduction, with coaches providing peer support to people whether or not they are still actively using substances.

While the above examples adopt harm reduction’s non-judgmental stance toward substance use, harm reduction is also being conceptualized as preparation for the journey toward long-term recovery that still focuses as much on abstinence as on broader quality of life. For example, motivational interviewing is a widely used form of brief counselling that supports people to prepare for, initiate, and maintain change. Peer roles include support for ‘pre-recovery’ in the path toward long-term recovery. One advocate concerned about siloes between harm reduction and abstinence-based treatment has called for “a substance-use care system that is built on the foundation of harm reduction and continually moves people toward a path of recovery”.

At the addictions policy level, the integration of harm reduction approaches is also associated with varying degrees of flexibility in the conceptualization of recovery. The Canadian Centre on Substance Use and Addiction has long embraced harm reduction approaches and has recently spearheaded a recovery campaign with a strong focus on hope and reducing stigma. Nevertheless, it continues to give abstinence a prominent place in its characterization of recovery, as in: “Recovery involves a process of personal growth along a continuum leading to abstinence” and further that “Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions”. After reinstating harm reduction as a core pillar of addictions policy in 2017, Canadian federal policy adopted an even more flexible characterization of recovery, as follows:

“It is important to recognize that there are many treatment paths, and recovery does not always mean abstinence. Recovery can also include improvements to other areas of life, such as stable housing, employment, mental health supports, or improved relationships”.

As will be explored below, the integration of mental health and addictions policies and services is also contributing to a more flexible conceptualization of addiction recovery.
Mental Health Recovery: Core Attributes

The mental health recovery movement has its roots in the 1960s patient liberation movement and the broader civil rights movement’s fight against discrimination. Much like the addiction recovery movement, the mental health recovery movement is focused on hope and empowerment. This positive focus was a reaction against the psychiatric system with its stigmatizing message that recovery from a diagnosis of mental illness was rarely possible, and with its use of coercive methods such as seclusion and restraint.

In contrast to the central role of abstinence in addiction recovery, the foundation of mental health recovery is the belief that cure is not necessary for people to have the hope of recovering a meaningful life. This belief is grounded in a growing body of research that is finding that people living with even the more severe forms of mental illness can experience a good quality of life, including optimism, meaningful employment, and personal autonomy. This conceptualization is most clearly expressed in William Anthony’s widely used definition of mental health recovery:

Recovery is 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.

Believing that recovery is possible even with ongoing illness is not the same thing as being opposed to medical treatment or replacing medical treatment with peer support and social services. Rather, as argued in the Mental Health Strategy for Canada, “Recovery seeks to promote people’s ability to choose and to ensure that options are available to meet the full range of people’s needs.” With this emphasis on choice and acceptance of ongoing symptoms, mental health recovery is similar to harm reduction.

The mental health sector is not uniform in this conceptualization of recovery, as at times recovery continues to be equated with cure alone. To take just one example, the United Kingdom’s Improving Access to Psychological Therapies program reports ‘recovery’ outcomes according to how many clients move below the threshold for clinical diagnosis of depression or anxiety. However, the mental health recovery movement stands clearly behind a more flexible definition of recovery, without the tension over whether recovery can only start with abstinence that exists in the addiction recovery movement.

While there is friction between mental health and addiction recovery when it comes to the necessity of cure and abstinence, there is considerable common ground when it comes to conceptualizing hope, self-determination, and everything that makes up a meaningful life (such as housing, work, relationships, community, and freedom from stigma and discrimination) as core attributes of recovery. As stated in the Mental Health Commission of Canada’s Guidelines for Recovery-Oriented Practice:
“Recovery approaches stand on two pillars. First, they recognize that each person is a unique individual with the right to determine his or her own path towards mental health and well-being. Second, they also understand that we all live our lives in complex societies where many intersecting factors (biological, psychological, social, economic, cultural, and spiritual) have an impact on mental health and well-being”.36

Further, while both mental health and addiction recovery view recovery as transformative at the personal and community level, mental health recovery is also held up as a driver of transformation at the system level. For example, a recovery orientation requires mental health service providers to focus as much on empowering people with lived experience as on providing expertise, and requires systems to focus as much on housing and employment as on access to health care.36

**Integrating Addiction and Mental Health Recovery**

Broader efforts have been underway for more than twenty years to improve the integration of mental health and addictions services and policies in general, as well as specifically for people with concurrent mental health and substance use disorders.37 Within this broader context, an emerging discourse is considering how to integrate mental health and addiction recovery in order to both take advantages of the commonalities and resolve the differences described above. For example, Davidson and White1 make note of the different approaches to ‘partial recovery’ but argue that these are minor in comparison with the shared focus on lived experience, self-determination, full and meaningful lives, and the potential for transformation. They propose the following integrated vision:

> “Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction experience and actively manage the disorders and their residual effects in the process of reclaiming full, meaningful lives in the community”.1

Since 2010, ten of thirteen provinces and territories in Canada have adopted integrated mental health and addictions frameworks, with varying degrees of specificity in their visions of recovery. For example, the clear language in this vision statement from British Columbia is an example from one end of the spectrum:

> “Children, youth and adults from all cultures in British Columbia achieve and maintain sound mental health and well-being, live in communities free of problems associated with substances, access effective support to recover from mental health and/or substance use problems that may develop over the lifespan, and lead fulfilling lives as engaged members of society without discrimination when these conditions persist”.38
The following definition of recovery from the Northwest Territories is similarly specific and flexible:

"Recovery is about being able to live a meaningful and satisfying life, whether or not there will continue to be ongoing symptoms or limitations caused by mental health problems, illnesses, or addictions. People can and do recover, but it's a deeply personal process that is unique to the individual".39

At first glance, Manitoba’s vision is a bit more ambiguous:

“All Manitobans enjoy the best possible mental health and well-being throughout life, and have welcoming, supportive and diverse communities in which to live, participate, recover and heal when facing mental health and substance use or addiction challenges”.40

However, this vision is also coupled with a specific clarification about the relationship between recovery and harm reduction:

“As part of its commitment to being a recovery-oriented system, Manitoba’s [substance use, addiction, and mental health] system will also be a harm-reducing system. Harm reduction and a recovery orientation are entirely consistent principles in a system in which services and supports are designed and delivered to recognize the uniqueness of each individual and support and empower individuals to make their own choices about how to lead their lives”.40

At the other end of the spectrum, governments have used the words recovery, mental illness, and addictions together without clarifying how recovery is being conceptualized. This vision statement from Ontario is one example:

"An Ontario where every person enjoys good mental health and well-being throughout their lifetime, and where all Ontarians with mental illness or addictions can recover and participate in welcoming, supportive communities".41

Saskatchewan’s vision statement is a bit more nuanced. However, what exactly is meant by “recovery to the greatest extent possible,” and how this might be different or similar for mental health and substance use problems, is similarly ambiguous:

“All residents of Saskatchewan will have access to appropriate and coordinated mental health and addictions services that promote recovery to the greatest extent possible, improve mental well-being, and ultimately enhance the overall health and vibrancy of our communities and our province".42
The Substance Abuse and Mental Health Services Administration in the United States developed an integrated vision for recovery in 2012 that is even more ambiguous because it includes contradictory messages:

“Overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional well-being”.43

On the one hand, both overcoming and managing are included, which implies that recovery does not have to start with cure or abstinence. On the other hand, the one example used is about abstinence.

As much as these integrated approaches to mental health and addiction recovery have highlighted the shared attributes, further work is needed to bridge the fundamental difference between cure not being necessary and abstinence being necessary for recovery. Harm reduction, which by definition is not conditional on abstinence, could help to provide a conceptual bridge between mental health and addiction recovery. However, of all the policies cited above, only British Columbia and Manitoba explicitly include harm reduction approaches. The next section of this paper introduces substance use and harm reduction into a two-continuum model of recovery and well-being that was developed in the mental health sector4, building on existing single and two-continuum models in both sectors.

Single and Two-Continuum Models

The belief that cure is not a necessary condition for recovery is consistent with another core concept in the mental health sector: the two-continuum model of mental health and mental illness (see Figure 1).43 According to the model, mental health and mental illness are two related but distinct continua. These two continua make it conceptually possible to have a mental illness and yet experience a high level of mental health, and conversely to have poor mental health without a mental illness. This model has been widely used to guide mental health policy development internationally and has been empirically validated in several countries. Most notably, Keyes44 found that 63% of American adults with mental disorders also have at least moderate mental health and another 6.5% had optimal mental health (‘flourishing’), and further found that 58% of American adults with poor mental health (‘languishing’) did not have a mental illness. These findings provide empirical support for the belief that recovery is possible even with ongoing mental illness. This model has been used to map recovery pathways45, and Mulvale and Bartram4 have also explored how this model opens up opportunities for alignment between mental health recovery and population health approaches to mental health promotion and well-being.
Figure 1. Two-continuum model of mental health and mental illness

This two-continuum model is an alternative to a single-continuum model of mental health, with mental health at one end and mental illness at the other. This single continuum model is still used in the mental health sector when simplicity is prioritized. For example, a colour-coded single continuum was first developed in the military as a quick self-assessment tool and is now being used in a variety of education-based programs. However, this simpler approach misses the important message conveyed by the two-continuum model, namely that it is as important to promote flourishing across the whole population as it is to provide access to treatment for mental health problems and illnesses.

In the addictions sector, various iterations of a single-continuum model are dominant. For example, the Screening, Brief Intervention and Referral to Treatment (SBIRT) program designed to encourage routine screening for substance use problems uses a single-continuum model with abstinence, experimental use, and social use at the low-risk end; binge use and harmful use in the middle; and substance disorder at the high-risk end. An alternative version from the government of British Columbia makes no mention of abstinence. Rather, this model introduces the concept of beneficial use at one end, moving across the continuum from non-problematic to problematic to chronic dependent use at the other end.

The concept of recovery capital has spurred the development of more complex models that are complementary to the two-continuum model of mental health and mental illness.
depicted in Figure 1. A bi-axial model conceptualizes remission and recovery capital as distinct but mutually-reinforcing axes, where progress in sustaining remission (i.e., abstinence) is reinforced by the availability of individual, social, and structural resources, and where such resources are in turn strengthened by sustained remission.\textsuperscript{15} Similarly, a recovery capital/problem severity matrix illuminates the different needs of people with high problem severity and high recovery capital compared with those who have high problem severity and low recovery capital.\textsuperscript{49}

Drawing on the various models from both sectors, a two-continuum model of substance use and harm is proposed in Figure 2. One continuum ranges from severe to no substance disorder, and the other continuum ranges from severe harms to no harms from substance use. While beneficial substance use is not explicitly included in the model, it fits conceptually in the top right quadrant, where people are not experiencing a substance disorder and where harms from substance use are minimal to non-existent. Abstinence could fit either within the top right or bottom right quadrant, depending on the extent to which a person who is not using substances may continue to experience substance-related harms from previous use.

**Figure 2. Two-continuum model of substance use and harm**

Much as with the two-continuum model of mental health and mental illness, harm and substance use disorder are conceptualized as distinct yet related continuum. This nuance is important for both substance use and mental disorders because diagnostic criteria rely heavily on one’s ability to function in everyday roles at work or at home\textsuperscript{50}. Nevertheless, this two-continuum approach makes it conceptually possible for recovery to include reducing the harms associated with a substance use disorder without necessarily reducing the level of substance use disorder. Preliminary empirical support
for this model can be found in the Canadian survey mentioned above: while people with active addiction reported poorer quality of life across multiple dimensions than people in recovery, large percentages of people with active addictions nevertheless reported having stable housing (65%), steady employment (53%), paying bills (42%), and participating in family activities (31%). This model applies to the whole population, including people with no substance use disorders who are nevertheless experiencing substance-related harms, and sets the stage for the fully integrated model of mental health and addiction recovery and well-being proposed in Figure 3 below.

**Figure 3.** Integrated model of mental health and addiction recovery and well-being

The proposed model integrates the two-continuum model of substance use and harm into the recovery and well-being model developed by Mulvale and Bartram as a conceptual framework for mental health policy. As with the earlier framework, both two-continuum models are rotated by 45 degrees to highlight how people can move upward toward recovery and well-being along any of the four distinct but related continua: by improving mental health, by reducing symptoms of mental illness, by reducing symptoms of substance disorder, or by reducing the harms associated with ongoing substance use. The continuum arrows are partially shaded and cut through by small circular arrows, to convey how people can move through the quadrants as they journey through life. The two flanking arrows illustrate how these journeys can be either helped or hindered by individual, social, and structural factors, whether they are referred to as risk factors or protective factors, as determinants of health, or as recovery capital. An integrated model underscores how these risk and protective factors are widely shared across the mental health and addictions sectors, whether it is the impact of adverse
childhood experiences, poverty, social support, coping skills, or genetic predispositions. The whole model is wrapped in a circle with a full range of supports including promotion, prevention, harm reduction, treatment, and support, with recovery and well-being positioned at the top.

This integrated model creates conceptual room on the right side for the experience of having a mental illness or substance use disorder (or both), while nevertheless having good mental health or reduced substance-related harms (or both). There is also conceptual room on the left side for the experience of either languishing or experiencing substance use related harms (or both), even without having a mental illness or substance use disorder. As someone with a mental illness may or may not have a substance disorder and vice versa, people’s experiences can occupy more than one quadrant at any one point in time. For example, someone with a severe mental illness, strong positive mental health, no substance disorder, and no harms from substance use would be in both the right and top quadrants; someone with a severe substance disorder, no mental illness, severe harms from substance use, and minimal mental health would be in both the bottom and left quadrants. This population health model is relevant for people with concurrent disorders, stand-alone mental health or substance use problems, or those at risk for one or both of the above, and also for promoting well-being and reducing harm in the population as a whole.

Conclusions

From a concept analysis comparing the uses and attributes of mental health recovery and addiction recovery, this paper identifies considerable common ground and one fundamental difference. Shared attributes of recovery are centred on four key shared values. First and foremost, recovery is possible. Whether people are experiencing substance use or mental health problems, hope is considered to be at the foundation of the recovery journey, and stigma is being challenged more and more by people’s first-hand accounts of recovery. Second, recovery is personal and self-determined. With strong roots in advocacy and lived experience, both the mental health and addictions sectors view each person’s recovery journey as personal and self-determined. Each unique path is best determined by each individual, with support from families, friends, peers, professionals, and the wider community. Third, recovery is about everything that supports a meaningful life, including adequate housing, meaningful activities and connections, and freedom from discrimination of all forms. Lastly, recovery is transformational. Addiction recovery has emphasized changes to one’s social identity through acceptance into a new recovery community. Mental health recovery has similarly focused on developing a new positive identity that is not associated with mental illness. Both the mental health and addictions sectors also identify recovery as a key driver of system transformation and changes in societal attitudes.

The fundamental difference concerns whether cure and abstinence are considered to be necessary conditions for recovery. The mental health recovery movement defines
recovery as living a meaningful life in the community even when there are ongoing limitations from mental illness. While there is tension and debate in the addictions field as to whether abstinence may or may not be a necessary condition for addiction recovery, abstinence continues to be the dominant point of reference. Nevertheless, with the emergence of long-term recovery, harm reduction, and integration between the addictions and mental health sectors, there are growing calls to make room for non-problematic substance use or recovery as defined by the individual.

The advantages of the integrated model proposed in Figure 3 are that it leverages the commonalities between mental health and addictions recovery, bridges the differences, and extends to the population as a whole. Framing recovery and well-being with four rather than one continuum leverages new possibilities for recovery and new reasons to hope. By highlighting how people can move between the quadrants, this model underscores the importance of self-determination and the uniqueness of each recovery journey. The inclusion of individual, social, and structural factors acknowledges the multiple dimensions of meaningful lives, including the importance of addressing stigma and discrimination. As an integrated conceptual framework, the model is intended to leverage the power of ideas to support transformation at the individual, system, and policy levels.

Integrating harm reduction into the model bridges the conceptual differences between mental health recovery and addiction recovery. As with mental health and mental illness, a two-continuum approach to substance use and harm provides a clear conceptual framework for recovery that can move forward on multiple fronts, whether the starting point is reducing harm, reducing symptoms of substance use disorder, reducing symptoms of mental illness, or improving positive mental health. This bridge is relevant for people with concurrent or stand-alone disorders and recognizes the close and often interconnected relationship between substance use and mental health.

The proposed model also extends to the whole population and breaks down ‘us and them’ barriers. The model points to common risk and protective factors for everyone, and conveys that a safe home, meaningful occupations, supportive friends and family, freedom from stigma and discrimination, and access to a full range of services and supports are important for everyone’s well-being, whether or not we have a mental health problem, a substance use problem, both, or neither.

Potential disadvantages of the proposed integrated model stem from the blurring of each element’s separate identity. Any form of mental health and addictions integration risks losing what is singular about each constituency. The addictions sector in particular has long raised concerns about being overshadowed by mental health, much as the mental health sector is itself overshadowed within the broader health system. The proposed model opens up the possibility of making progress in reducing harm or strengthening well-being even with ongoing symptoms of mental health or substance
use problems, but this may not be meaningful to people who are advocating for access to professional treatment first and foremost.

There are also potential disadvantages that come from integrating harm reduction into a broad population health framework. Such integration could undermine the role of the harm reduction movement in advocating for the citizenship rights of substance users. Conversely, opening up the conceptualization of recovery to the possibility of starting with harm reduction without any reduction in substance use runs the risk of limiting the reach of the abstinence model. Moreover, harm reduction is a highly polarizing term that is strongly associated with debates over drug use and legalization. The inclusion of harm reduction may render the proposed framework too controversial to be of any practical use. Concepts such as long-term recovery may be able to extend the reach of recovery services and supports to people in ‘pre-recovery phase,’ without needing to explicitly address the question of how to integrate harm reduction into abstinence-based approaches to recovery.

This concept analysis is grounded in empirical examples from policy documents and other literature. The proposed model is not intended to be definitive, but rather to stimulate further discussion and help to clear a path toward a shared vision for recovery and well-being. These issues will be further explored through interviews and focus groups as part of a broader qualitative research project. With continued efforts to integrate the mental health and addictions sectors and better serve the needs of people with concurrent disorders, with two strong recovery movements working in parallel but not in tandem, and with growing interest in harm reduction approaches in the face of the opioid crisis, there is both a window of opportunity and a pressing need for such a shared vision.

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