Introducing a recovery group to a forensic psychiatric service

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A group derived from the principles of the recovery movement was introduced in a regional secure unit. User feedback was positive but attendance was variable.

The recovery movement encompasses a variety of perspectives on recovering from distressing and unusual experiences, representing the views of service users, carers and professionals. A unifying theme is the centrality of hope and a belief in the possibility of improvement in the lives of people who have such experiences. Other important components are a move away from an exclusively medical understanding of distress and a view of individuals as experts on managing their own experiences and active participants in the process of recovery. There is also an emphasis on the need for social recovery and inclusion, and a recognition of the possibility of an individual living a meaningful and fulfilling life independent of the nature of their experiences (Allott & Loganathan, 2002, May, 2004, Roberts & Wolfson, 2004).

This approach is very different from that typically seen within forensic psychiatric settings, which tend to be dominated by medical understandings and approaches to treatment and an orientation towards control rather than the promotion of autonomy. Recipients of forensic services may therefore be encouraged to define themselves as passive victims of an illness process who require expert intervention and monitoring. Furthermore, being continuously under scrutiny, especially for indicators of risk, may exacerbate unusual experiences of a persecutory nature, or those whose function is to

defend the individual against threats to their self concept. The impact of implementing a recovery-based approach in forensic settings is therefore inherently limited by the nature and priorities of the service. Nonetheless, interventions at a number of levels could result in service users being encouraged to view themselves in more positive ways and gaining hope for the future. These include policy formation, staff training and supervision and direct interventions with service users. With the recognition that the impact would be limited by the nature of the setting, it was decided to attempt to introduce a "recovery group" for service users within a regional secure unit. The aim of the group was to increase awareness of alternative ways of understanding and managing distressing and unusual experiences and to provide users with an opportunity to share experiences and gain mutual support.

Group structure and content

The group was organised by a team of facilitators with multidisciplinary membership (including representatives from psychology, psychiatry, occupational therapy and nursing). Suggestions for session content were sought from service users through writing to all users individually and a discussion at the service user's forum. Further ideas were generated from published research on what service users found to be helpful, such as Strategies for Living (Faulkner & Layzell, 2000) and the Rethink self-management project (Rethink, 2003), and from networking with external service users and professionals with an interest in recovery. Where topics were identified that could not be presented by the group facilitators, contributions from other professionals from within the service and external facilitators were sought.

Sessions took the format of educational workshops lasting between 1 and 2 hours, with varying degrees of structure depending on the topic. All service users received an invitation to attend every session and posters advertising the sessions were displayed on the unit. Sessions took place in the conference room, based on the 18-bed rehabilitation ward. Users from the adjoining 10-bed acute admissions ward are allowed access to the rehabilitation ward depending on individual risk assessment, and some were therefore able to attend the group. An initial series of ten weekly sessions was run, followed by an evaluation session to discuss the future of the group. At this session, users felt that the group had been valuable but that enough material had been covered in the sessions so far. It was therefore decide to take a break and offer the group again when a new group of users would be in the service. A further series of ten fortnightly sessions was run six months later, repeating some of the earlier sessions and introducing new ones. Further new sessions and repeats of previous sessions were planned but did not take place due to a restructuring of the service. The session topics and the number of service users attending each session for both series are shown in Table 1.

Table 1 about here

Evaluation

Following the first series of sessions a short questionnaire was sent to all the service users on the unit by post. The questionnaire asked users what they had thought of the group, whether they had any suggestions for the group and if they had any reasons for not attending the group. Questionnaires were sent to twenty-eight users who had been on the unit during the group, three were returned by users who had attended some

group sessions and one was returned by a user who had not attended. Positive comments about the group were that it was very good and that it was good to share ideas, problems and insights. Negative comments were that it was difficult to understand some of the long words that were used and that there had not been enough people in the sessions. Suggestions for the group were that it should continue, that the ideas should be broken down more and that attendance should be made compulsory. Reasons for not attending were that users had been attending other sessions and feeling that their own understanding of their difficulties was not taken seriously.

Following the second series of sessions, it was felt that a better response rate would be obtained through approaching users for interviews about the group. A short semi-structured interview was developed by the group facilitators asking about users' awareness of the group, which sessions they had enjoyed, suggestions for future sessions and reasons for not attending. Twenty-four users had been present on the unit during the group, seventeen participated in an interview, three were not approached on nursing recommendation and four declined to take part.

Twelve users said they had known when the group was taking place, three said they had not, one said that he could not remember and one said he had known sometimes. Those that said they did not know about the group were all on the acute ward during the time the group was running, so their awareness of the group may have been affected by their mental state or restrictions on their movements within the unit. Nine users said they had attended at least one session of the group. Four users said they had enjoyed the music therapy session. Four users said they had enjoyed meditation and relaxation sessions (possibly also referring to the mindfulness session). Two users

said they enjoyed the self help for hearing voices session and two said they had enjoyed the medication session. One user each said they had enjoyed the spirituality, balanced lifestyle and aromatherapy sessions. Suggestions for future sessions included having more of the same, with music and relaxation being identified by three users. Other suggestions were drama, food, herbal remedies, sport, Christianity, Alcoholics Anonymous, exploring different kinds of religion, building self confidence, coping with medication side effects, having people from outside share their experiences of mental health services, moving on from hospital, rights in relation to getting out of hospital and discussing how you feel about being in hospital.

The most common reason for not attending sessions, given by 7 users, was not being interested or thinking that they would be boring. Five users said they had not been aware of the sessions or did not have the leave to attend. Four users said that they had not been in the mood or were having too many difficulties. Two users said they had been busy doing other things, one had forgotten to attend some sessions, one had not wanted to be in a room with lots of other people and one said he did not need to recover.

Discussion

The recovery group was introduced in an attempt to expose service users to alternative ways of understanding and managing distressing and unusual experiences. Attendance at group sessions was variable and seemed to be dependent on the needs and interests of the users of the service at the time, with sessions that were well attended in the first series not being well attended when they were repeated for a different cohort of users.

Where service users did not attend the group at all, this seemed to reflect a general lack of engagement with the service and a disparity between the service users perceptions of their needs and what the service was attempting to provide. Although the intention of the group was to introduce and validate alternatives to the traditional psychiatric approach that might be more acceptable to service users, they were inevitably suspicious of an intervention that was provided by a system in which such an approach remains dominant. From the response to the two attempts to evaluate the group, it is clear that more pro-active engagement with service users is more effective. Engaging with users in this way in order to explain the purpose of the group prior to the next series of sessions may improve attendance. Using the results of the second evaluation to guide future selection of topics may also result in service users both feeling that sessions are meaningful and that their views on what will benefit them are being respected.

Other approaches are also needed to introduce a recovery ethos into the wider functioning of the service, so that the effectiveness of such a group is enhanced and not diluted by the service users' more general experience. During the course of the sessions several nurses asked or suggested that similar sessions be provided for them, in order to enhance their own understanding and practice. Training in recovery principles and self-management techniques is therefore being offered to all disciplines.

Table 1. Session topics and number of users attending.

Series 1	Users	Series 2	Users
Recovery (*led by psychologist)* Introducing the idea of recovery and looking at published accounts of recovery	5	**Wellness Recovery Action Plans** (*led by psychologist)*	0
CBT for coping with voices and unusual ideas (*led by psychologist)*	3	**Aromatherapy and massage** *(led by external aromatherapist)*	8
Medication *(led by psychiatrist)*	7	**Meditation** *(led by education tutor with personal interest)*	2
The effect of trauma on wellbeing (*led by psychologist)*	0	**Medication** *(led by psychiatrist)*	2
Health, fitness and well being *(led by physiotherapist)*	2	**Self help groups for hearing voices** *(led by members of local Hearing Voices Group)*	4
Spirituality and well being *(led by chaplain and psychologist)*	4	**Spirituality and well being** *(led by chaplain and psychologist)*	2
Wellness Recovery Action Plans *(led by external trainer)* A self management tool developed by service users in the USA	2	**Wild Things** *(led by external dramatherapist*) Environmental art therapy, exploring emotion through storytelling, drama and sculpture using the natural environment	3
Psychic Self Defence *(led by psychologist with personal interest)* Using occult techniques to defend the mind	3	**Life in Balance** *(led by occupational therapist)* Exploring the importance of achieving a balance in types of activity for well being	2
Street Drugs and wellbeing *(led by psychiatrist)*	5	**Music therapy** *(led by music therapist)*	5
Meditation *(led by education tutor with personal interest)*	2	**Mindfulness** *(led by external mindfulness trainer)*	4
Mean no. of users attending	3.3	Mean no. of users attending	3.2

References

Allot, P. & Loganathan, L. (2002). *Discovering hope for recovery from a British perspective: a review of literature.* Centre for Community Mental Health, UCE, Birmingham.

Faulkner, A. & Layzell, S. (2000). *Strategies For Living: A Summary Report Of User Led Research Into People's Strategies For Living With Mental Distress.* London: Mental Health Foundation.

May, R. (2004). Understanding psychotic experiences and working towards recovery. In McGorry, P. & Gleeson, J. (Eds.) *Psychological Interventions in Early Psychosis*. Chichester: Wiley

Rethink (2003). *The Experiences and Views of Self-Management of People with a Diagnosis of Schizophrenia.* London: Rethink.

Roberts, G & Wolfson, P. (2004). The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment*, 10, 37-49.

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