The engagement nexus and psychosocial recovery

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Push 1- shift from clinical definitions of recovery to psychosocial recovery;
Push 2- mental health recovery oriented services and policy;
Push 3 – embedding of consumers and carers within organisational service planning and design;
Push 4 – need for an evidence base.
Nexus: “a connection or series of connections linking two or more things…”

Word Origin: “from Latin (‘nectere’ a verb - to tie or bind together).”
• “Patient” engagement posited as:

“a necessary condition for the re-design of the health care system, the “holy grail” of health care and next block buster drug of the century” (Carmen 2013, p. 223).
Many definitions of recovery exist, but shared across these definitions is an emphasis on recovery as an individual process (or journey) involving much more than symptom remission. Instead, recovery involves development in life domains considered subjectively important to the person, commonly related to progress in normative activities such as education, employment, housing and social relationships. Autonomy and choice in mental health care are considered central to the concept of recovery.

(Whitley, Palmer, Gunn 2015, p.2)
Individual engagement in ‘recovery process or journey’.

Engagement in normative activities as enactment of meaningful, subjective life domains.

Engagement in care choices and decision-making.
• Engagement is the nexus in consumer and carer involvement, psychosocial recovery outcomes and recovery oriented mental health services.

• *But, how well is the concept examined and understood?*
• Prioritise “engagement” with people living with mental illness to meet needs (p.15);

• “Engagement” in an active life as part of the recovery definition (p.41).
• Increase “engagement” through e-health with other people and services (p.42).
• Community mental health services as a conduit for “engagement” between recipient and provider of services (p.44).
• “Engage” particular (Metis) communities for better mental health (p.49)
Good practice for mental health workers with carers: “training in engagement strategies” (p.34).
Recognition that engagement in treatment is affected by other religious and social factors (p.62)
Closing the Gap: Priorities for essential change in mental health

- Engaging in change across society.
5. Partnership and communication

Recovery oriented mental health practice:
- acknowledges each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers to provide support in a way that makes sense to them
- values the importance of sharing relevant information and the need to communicate clearly to enable effective engagement
- involves working in positive and realistic ways with individuals and their carers to help them realise their own hopes, goals and aspirations.

Recovery approaches are different depending upon where a person is on their recovery journey. During an acute phase of illness, the person’s capacity may be impaired to the extent that alleviation of distress and the burden of symptoms, as well as safety, is the primary focus of treatment and care. Regaining capacity for self-determination or deeper engagement should be a focus in the next stage of treatment and support. At later stages, when capacity is improved, there are opportunities for the person to consider broader recovery strategies.
Engagement Implicit not Explicit

Figure 3: The concept of recovery
Engagement defined in a variety of ways

- Reaching out to connect with others
- As a conduit for treatment and support
- As a transaction based on service delivery and receipt
Concept of engagement needs greater attention and focus in current work (Push 3)

A Multidimensional Framework For Patient And Family Engagement In Health And Health Care

Levels of engagement

Direct care
- Patients receive information about a diagnosis
- Patients are asked about their preferences in treatment plan
- Treatment decisions are made based on patients' preferences, medical evidence, and clinical judgment

Organizational design and governance
- Organization surveys patients about their care experiences
- Hospital involves patients as advisers or advisory council members
- Patients co-lead hospital safety and quality improvement committees

Policy making
- Public agency conducts focus groups with patients to ask opinions about a health care issue
- Patients' recommendations about research priorities are used by public agency to make funding decisions
- Patients have equal representation on agency committee that makes decisions about how to allocate resources to health programs

Factors influencing engagement:
- Patient (beliefs about patient role, health literacy, education)
- Organization (policies and practices, culture)
- Society (social norms, regulations, policy)

Source: Authors’ analysis. Note: Movement to the right on the continuum of engagement denotes increasing patient participation and collaboration.

Carman et al., 2013, p.225
Challenges for engagement

- Roots in civic engagement
- Community engagement
- Community-university engagement
- Learner/student engagement
As part of push 4

The CORE Study – a stepped wedge cluster randomised controlled trial to test a co-design technique to optimise psychosocial recovery outcomes for people affected by mental illness

Investigating Team: Dr Victoria Palmer, Professor Jane Gunn, Professor Helen Herrman, Dr Rosemary Callander (Tandem representing Victorian Mental Health Carers), Mr Wayne Weavell (Victorian Mental Illness Awareness Council, VMIAC), Assoc. Professor John Furler, Dr Donella Piper (Independent Consultant Honorary), Assoc. Professor David Pierce, Professor Rick Iedema (University of Tasmania and the New South Wales Agency for Clinical Innovation).

CORE aims to test if an Experience Based Co-design intervention will result in:

1) improved individual psychosocial recovery outcomes (primary outcome);
2) improvements to carer well-being and changes to staff attitudes to recovery and the recovery orientation of services (secondary outcomes).

Available Published Study Protocol: Palmer V, Chondros P, Piper D et al., 2015. The CORE study protocol: a stepped wedge cluster randomised controlled trial to test a co-design technique to optimise psychosocial recovery outcomes for people affected by mental illness in the community mental health setting. BMJ Open; 5(3): http://bmjopen.bmj.com/content/5/3/e006688
<table>
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<th>Participant &amp; Eligibility Criteria</th>
<th>Outcome Measure</th>
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| **Consumers of mental health community support services in Victoria**  
16-65 years old  
Disability attributable to psychiatric condition  
Permanent impairment  
Substantial psychosocial functioning for communication, self-care, learning, social interaction and self-management. | **Primary Outcome**  
| **Consumers Carers**  
18 years and over  
Carer of service user in receipt of mental health services at participating sites. | **Secondary Outcomes**  
| **Staff in teams of participating services**  
18 years and over  
Study design

The diagram illustrates the study design with clusters labeled from Cluster 1 to Cluster 11. Each cluster is assigned to one of the four phases: Control, Intervention, Post-intervention, and Follow-up. The timeline spans from Year One to Year Four, with specific time points marked as T0 (Baseline), T1 (9mth follow-up), T2 (18mth follow-up), and T3 (27mth follow-up).
The EBCD based intervention

[Stage One] INFORMATION GATHERING

TOUCH POINTS COMPUTER ASSISTED TELEPHONE INTERVIEW (CATI)
All service users and carers enrolled in the study at participating services are invited to complete a CATI to identify 'touch points' reflecting positive and negative experiences of services related to recovery.

FACE-TO-FACE INTERVIEWS
Conducted with 3 service users and 3 carers to develop in-depth understanding.

FOCUS GROUP EXPLORATION OF TOUCH POINTS
Separate focus groups with service users, carers and staff (8-10 participants in each) conducted at each site to explore the touch points and develop further understanding.

TRAINING FOR PARTICIPATION
Service users, carers and staff are offered training to enable active participation in meetings and understanding of methodology.

[Stage Two] CODESIGN PHASE

COLLABORATION GROUP MEETING 1
Reviews service stories and experience touch points data. Identifies three objectives for co-design.

CO-DESIGN GROUP MEETING 1
Reviews objectives, explores service policies and structures related to touch points, and completes process mapping.

CO-DESIGN GROUP MEETING 2
Reviews and discusses examples of good practice (informed by evidence reviews and syntheses).

CO-DESIGN GROUP MEETING 3
Develops action plan for improvements and formulates recommendations for the Collaboration Group.

COLLABORATION GROUP MEETING 2
Reviews co-design groups' action plans and implements plan

Implementation of the action plans

Weeks 1-6
Weeks 7-14
Weeks 15-16
Week 17
Weeks 18-19
Weeks 20-21
Weeks 22-23
Weeks 24-25
Weeks 26-30
Sartre’s ethics of engagement (originally about the need for socially responsible writing and the question of human existence).
Engagement has three main conditions: awareness, responsibility and respect.

AWARENESS – reflection and disclosure of injustice;
RESPONSIBILITY – encouraging others to act and be responsible through acts/actions of disclosure;
RESPECT – for others both the audience and those suffering.
“Existential engagement...is a social virtue that entails obligations to others. Engagement instructs us to care about the civic conditions through which our identities are shaped and sustained” (Storm 2006, p.103).
Engagement is:

- Relational (identity constituted relationally);
- Dialogical (conversation);
- Moral & Ethical;
- Invoked, evoked and provoked.

An essential ingredient:

“our engagement with the world around us is both profound and crucial” (Dowrick 2009, p.173).
• Thin use of concept of engagement may result in a “transactional” view of engagement;

• Engagement is tied to concept of psychosocial recovery, co-production/co-design and recovery oriented systems.


Department of Health Australia. 2013. *A national framework for recovery-oriented mental health services: Policy and theory* Canberra: DoHA.


Mental Health Consumer Outcomes Taskforce


