EDITORIALS

Choice in mental health: participation and recovery

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Summary The Royal College of Psychiatrists has established a Working Group on Choice in Mental Health and held a conference to include service users in formulating a challenging view of the choice agenda for mental health. This is set out here to stimulate wider interest. Choice-based practice develops in a climate of trust and information, and goes beyond simple variety or individual consumerism. For some service users, limited initial areas of choice can be of great importance, but a true culture of choice requires the widespread participation of service users and carers in service improvement. It is important that psychiatrists champion the empowerment of their patients through choice, in policy and training, and in clinical practice.

Declaration of interest None.

Choice in healthcare

Choice can be defined as the selection of one or more options among a variety available, and in healthcare this can be seen as a guarantor of patient autonomy and dignity. The notion of choice bringing power and control to patients as customers is an attractive one. However, it is important that choice in areas such as mental health is not simply equated with health consumerism and competition, but rather emphasises collaboration between service users and service providers and service user empowerment.[1]

Enabling choice for patients and their carers (even when they may disagree with each other) allows them to take more responsibility for the patient's care and to enjoy truly open relationships with treating doctors and other healthcare professionals. For professionals, choice, as part of an honest participative relationship with the patient, is key to the development of professionalism in mental healthcare.[2]

Trust and information

Trust is a crucial first step on the road to choice-based practice, as is a high level of engagement of the professional in their relationship with the patient. People with mental disorder are often alienated from society and healthcare services. This is especially true of those with serious mental illness, people from Black and minority ethnic groups, detained individuals, those in prison, and the young (who may feel more strongly about choice than their elders). Such groups in reality often have little choice. Therefore, a dialogue building trust between patients and professionals in many settings is required to improve awareness and participation, and eventually give the individual the choice to accept, or reject, a service. It is only through dialogue that many disparities in the effective delivery of treatment to those with mental ill health can be addressed. Those disparities notably include both mental and physical healthcare for people with mental illness.

Effective choice in mental health requires trustworthy information. Psychiatrists have been better served in this regard than patients, for whom reliable and understandable guidance on mental health problems, disorders, treatments and services has been hard to come by. Many internet sources, although widely accessible, remain highly unreliable and even risky, based on individual anecdote in an often stigmatised area of service provision. It is reassuring that the Royal College of Psychiatrists now provides world-leading online mental health information (see www. rcpsych.ac.uk) and UK governments are also developing web-based resources (e.g. www.nhs.uk/Livewell/MentalHealth/Pages/Mentalhealthhome.aspx in England). It is as yet hard to glean a clear user perspective from, for example, the results of Healthcare Commission (Care Quality Commission from April 2009) patient surveys in mental health, although in general healthcare these are becoming a useful measure of overall quality.

Choice-based practice and services

Many contemporary developments in the mental health professions must combine to support the values,[3] attitudes and skills needed to make patient choice a reality. Those values are: commitment to social inclusion,[4] reflective practice and the principles of recovery,[5] as well as the person-centred skills and competences[6] central to modern psychiatric training. User-led research[7] complements evidence-based medicine and must inform such commitments.

Patients must be given a chance to choose (or change) their psychiatrist, where possible, just as they choose their family doctor. For example, the current move away in England from purely catchment area-based services may enable this.

Further, unless it is necessary to detain an individual for treatment under mental health legislation or use powers for compulsion in the community, individuals may choose not to see a psychiatrist, nor to accept treatment. Given that the first port of call for mental distress may be a family doctor, a counsellor or perhaps a faith leader, the choice agenda demands further outreach and integration of mental health services into the community. Early contact with psychiatry must become a more natural choice for patients.

Services which embrace choice must be crafted towards the mutual endeavour of excellence in clinical assessment and treatment, and attaining recovery. The development of services should reflect the preferences of patients and carers. Collectively, service users increasingly influence the design, delivery and evaluation of services. Indeed, choice in mental health at times may be exercised more substantially at a collective level, beyond the individual point of contact with services when the person may be at their most vulnerable and unable to participate fully. Advocacy may be particularly helpful to vulnerable individuals, as may new mechanisms for decision-making in advance of illness. For many of the most vulnerable groups, however, a wider range of options of services attuned to their specific local and cultural needs would be the simplest way to enable choice.

Emerging choices

Treatment options

Increasingly, treatment options other than hospital admission are available to service users, for instance crisis resolution and home treatment[8] and crisis houses,[9] although patients must not be unreasonably deprived of the choice of hospital admission where this is the safest and most effective place of treatment and when it is preferred by the patient and carer. User-led services, crisis houses and self-help groups may become increasingly important in future years. For young people, the most effective service innovations seem to be the ones that enable choice.[10]

Choice of medication

Research comparing medication and psychotherapy in the treatment of depression suggests that preference and strength of preference are important in determining uptake and completion of treatment.[11] Patients rate the ability to choose their medication as highly important, both in surveys by campaigning groups (e.g. Hill & Laugharne[12]) and also when asked by their own psychiatrist. However, even though a discussion about medication choice is endorsed by the National Institute for Health and Clinical Excellence, the performance of psychiatric services in this area is often poor.[13]

Modest choices

Other key areas for choice cover safety, vulnerability and dignity, for example availability of single-gender wards. For those in the most restrictive environments (e.g. forensic in-patients) emerging yet modest avenues of choice and autonomy in the physical environment and in daily life may be particularly important for recovery and should be promoted by psychiatrists.[14]

Mechanisms for choice

The agenda of choice and the principle of self-care for individuals with long-term conditions have led to personal budgets in various forms being recently proposed and piloted in England. Many are concerned that imminent public spending cuts will force both budget-holding and non-budget-holding individuals to make difficult price-driven choices.

The consumerist view of choice assumes that patients will benefit from a variety of providers offering a range of services which differ in approach, quality, evidenced outcomes and price. However, a complex diversity of evolving services in mental health has sometimes been associated with unseemly boundary disputes (e.g. diagnostic, geographical, risk) and an interface with patients and carers which places unreasonable burdens on them and damages outcomes. It is to be hoped that innovative solutions will emerge across the UK, proven by systematic comparative evaluation between its different jurisdictions.

Compulsion and choice

In addition to resources, mental incapacity and/or legal compulsion often impose limitations on individual user's choice in psychiatry. Public and collective user participation in service policy and design offer some solution, as does advocacy at the point of service.

The psychiatrist's necessary role in compulsory detention and decision-making dissuades many observers from accepting our commitment to empowerment and choice. This is a stigma the profession has to bear. However, a concern for safety is a values-based approach and should always be understood as the first step in a pathway of empowerment and increasing choice, leading towards recovery and autonomy. Even in the most restrictive or adversarial setting, psychiatrists should always seek to be the early champions for choice, sharing with a disempowered patient a vision of their future freedoms.[14]

Conclusion

Choice and participation must be central to future policy of the Royal College of Psychiatrists. Many psychiatrists have long supported the participation and empowerment of patients and it is important that all psychiatrists now intelligently champion the idea of choice, as discussed here, with patients, trainees and policy makers.

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Philip Sugarman is Elected Member, **George Ikkos** is Honorary Treasurer and **Sue Bailey** is Registrar of the Central Executive Committee, Royal College of Psychiatrists, London.

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Does the scientific evidence support the recovery model?

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Summary This editorial addresses the question of whether some of the basic tenets of the recovery model – optimism about outcome, the value of work, the importance of empowerment of patients and the utility of user-run programmes – are supported by the scientific research.

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Recovery model

The recovery model is a social movement that is influencing mental health service development around the world. It refers to the subjective experience of optimism about outcome from psychosis, to a belief in the value of the empowerment of people with mental illness, and to a focus on services in which decisions about treatment are taken collaboratively with the user and which aim to find productive roles for people with mental illness.[1–3] Flowing from this model is a renewed interest in educating users about illness management, in tackling stigma and in the creation of service user-run services that offer advocacy, mentoring and peer support via such mechanisms as user-run drop-in centres. Collaborative models, like the psychosocial clubhouse and educational programmes that involve both professionals and clients as teachers, are seen as important elements of recovery-oriented services.[1–3]

A social movement is a form of social action based on shared values and aspirations, and it is not necessarily founded upon scientific evidence. Do the research data, in fact, support optimism about outcome from serious mental illness, the value of work, the importance of empowerment and other tenets of the recovery model?

Recovery from schizophrenia

A large body of data, including several recent studies, suggest that optimism about outcome from schizophrenia is justified. A meta-analysis of over a hundred outcome studies in schizophrenia conducted in high-income countries throughout the 20th century[4] assessed whether individuals had achieved 'social recovery' (economic and residential independence and low social disruption) or 'complete recovery' (loss of psychotic symptoms and return to the