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Opinion Article

Recovery-oriented Care in Public Mental Health Policies in Spain: Opportunities and Barriers

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Recovery-oriented care is the proposal incorporated in the new mental health strategic plans of both the World Health Organization and the Spanish National Health System. This article takes a journey from the initial proposals of the recovery model to the way recovery-oriented care is currently defined, understood as a community intervention, person-centred, and based on rights. The existing consensus around the CHIME model is also explained in order to understand what kind of interventions are needed to transform mental health services. Likewise, some of the main existing programs and projects to promote recovery-oriented care are presented, and a number of existing barriers to their implementation are analysed.

La atención orientada a la recuperación en las políticas públicas de salud mental en España: oportunidades y barreras

Palabras clave:
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R E S U M E N

La atención orientada a la recuperación es la propuesta incorporada en los nuevos planes estratégicos de salud mental tanto de la Organización Mundial de la Salud como del Sistema Nacional de Salud español. Este artículo hace un recorrido desde las propuestas iniciales del modelo de recuperación hasta la forma en que se define actualmente la atención orientada a la recuperación, entendida como una intervención comunitaria, centrada en la persona y basada en derechos. También se explica el consenso existente en torno al modelo CHIME para comprender qué tipo de intervenciones se necesitan para transformar los servicios de salud mental. Asimismo, se presentan algunos de los principales programas y proyectos existentes para promover la atención orientada a la recuperación y se analizan ciertas barreras existentes para su implementación.

Following the guidelines of the United Nations (2006) and the World Health Organization (2013, 2019e, 2021b), the mental health and addictions strategic plans in our country currently propose a person-centred, community-based, recovery-oriented, and rights-based care. On December 2, 2021, the Interterritorial Council approved the new Mental Health Strategy of the National Health System (ESM-SNS, for the Spanish acronym) for the period 2022-2026 (Ministerio de Sanidad, 2022). This document considers personal recovery as one of its principles and includes care based on the recovery model in the community as one of its strategic lines. This paradigm shift had already begun previously in the mental health and addiction strategic plans of some regions. Among them, we can find the regional governments of Andalusia (Consejería de Sanidad, 2016), Valencia (Generalitat Valenciana, 2016), Catalonia (Generalitat de Catalunya, Departament de Presidència, 2017), and Castilla-La Mancha (Consejería de Sanidad de Castilla-La Mancha, 2018). And it is to be expected that, with the new ESM-SNS, other regions will follow the same path in their future strategic planning. All these strategic plans are aligned with the current proposals of the WHO, which highlights "the need to provide high quality, person-centred, recovery-oriented mental health services that protect and promote people's human rights." (World Health Organization, 2021b, p. 21).

Beyond the good intentions of these strategic plans, there have been very few changes in recent years in mental health services in Spain. Bearing this in mind, this article has two objectives: (a) to describe what is currently understood by recovery-oriented care, making a brief tour of the path that has led us to this point of conceptualization, and (b) to reflect on the implementation of this

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paradigm shift in the mental health public policies in Spain, paying special attention to the opportunities to deploy new programs and projects, and the resistances to change the current practices that must be overcome.

Recovery-oriented Care: Origin and Current Distinctive Features

The recovery model has its roots in the context of deinstitutionalization, with the movements of users and survivors of psychiatry advocating for self-determination and fighting against involuntary admissions and forced treatment (Resnick & Rosenheck, 2006; Webb, 2011). The publication of the article "Recovery from mental illness: The guiding vision of the mental health service system in the 1990s", by William Anthony (Anthony, 1993), could be considered as the date of birth of the model. In this text, the author systematizes the previous ideas, defines the concept, and establishes the basic proposals for its implementation.

The new Mental Health Strategy of the Spanish National Health System paraphrases the foundational definition of the model offered by Anthony (1993) to define recovery as "A unique and individual process linked to the personal development of each individual. This process is linked to a substantial change in attitudes, values, feelings, goals, and roles of a person with mental health problems towards the construction of a life project that is not focused on the diagnosis and symptoms of the health problem, but instead on the leading role that the person plays in her/his own life. This is linked to the discovery or rediscovery of a sense of personal identity separate from illness or disability." (Ministerio de Sanidad, 2022, p. 21)

In this paradigm, the remission of symptoms and the functional adaptation of a person to society are no longer the main objectives of public policies (Pilgrim, 2008). On the contrary, social and health care for people with mental health problems must now be oriented towards promoting a satisfying life, with hope and contributions to society, developing a meaning and purpose in one's life, beyond the presence or absence of symptoms (Anthony, 1993; Copeland, 2004; Shepherd et al., 2008). From this perspective, personal recovery implies living according to one's own values and preferences. Therefore, self-determination is considered a prerequisite for a recovery process (Copeland, 2004; Mancini, 2008; Mattner et al., 2017; Piltch, 2016). For this reason it is highlighted that service providers have the responsibility to promote, recognize, and respect self-determination of people with mental health problems (Cook and Jonikas, 2002; Copeland, 2004).

In the first decade of this century this paradigm shift was adopted by most of the mental health strategic plans of the Anglo-Saxon countries (Leamy et al., 2011) and by several countries in northern Europe (Slade et al., 2008). Since then, several psychometric instruments have been developed to measure personal recovery, based on the perspective of the users, some of which have shown good psychometric properties (Penas et al., 2019). Likewise, some programs developed to promote self-determination in the personal recovery process, such as the Wellness Recovery Action Plan (Copeland, 1997), has been recognized by the United States Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice (Copeland, 2014).

However, as these strategic plans began to be implemented, and as the recovery model was extended to new contexts, various critical voices emerged against it. First, both from the mad activisms and from the academy it has been remarked that these interventions have lost sight of the roots from which the model emerges, in such a way that they have been implemented without a human rights perspective. In fact, some authors consider an 'abuse' of the recovery concept the idea of "compulsory detention and treatment aid recovery" (Slade et al., 2014, p.12). Similarly, it has been observed that public policies and research have been neglecting "the material, social, cultural, political, and economic contexts in which people pursue recovery" (Rowe & Davidson, 2016, p. 15). From this perspective, the exercise of citizenship rights is considered as a condition of possibility for the recovery process: "Supporting people with mental illness in exercising the rights and responsibilities of citizenship might be a pre-condition for their recovery, not an eventual reward contingent on the person overcoming his or her disability first" (Pelletier et al., 2015, p. 2).

Second, it has been criticized that the emphasis placed on self-determination reflects the individualistic values underlying American/British culture, but that "as the concept of personal recovery has spread throughout the world, the emphasis on 'self-determination' has come to be increasingly questioned" (Davidson & González-Ibáñez, 2017, p. 196). This approach has proven to be culturally inappropriate, for example, when it was implemented in China (Davidson & Tse, 2014) and India (Bayetti et al., 2016), or even among Hispanic ethnic minorities within the United States (Davidson & González-Ibáñez, 2017). This perspective advocates for a recovery-oriented care that takes into account the family and community context of the person.

Finally, both scientific literature and WHO currently prefer to use the expression recovery-oriented care, instead of recovery model, since it is considered a practical orientation about the objectives of interventions, the sort of care that mental health services should provide, and the rights and roles of users, rather than a unitary theory about what health and illness are (Thornton, 2012; Thornton & Lucas, 2010).

As a matter of fact, the World Health Organization's QualityRights Initiative introduce this perspective of community-based mental health services that promote person-centred, recovery-oriented and rights-based health services, as a result of a "considerable dialogue, debate, and concerns expressed" (Funk & Drew, 2020) with representatives of the Committee on the Rights of Persons with Disabilities, an initiative that recovers the original demands of the movement of users and survivors of psychiatry.

At this point, we can find two different positions in relation to how to incorporate the recovery-oriented care approach in mental health services. In one of them, the replacement of the biomedical paradigm is proposed. This is the position of mad activism, which raises that "We are dealing with 'problems of living' not 'illnesses'" (Johnstone, 2006, p. 81), and also the orientation of all the international organizations aligned with the international human rights' legal framework, like WHO through the Quality Rights Initiative. For example, the Council of Europe, through the commissioner on human rights, emphasizes the need to promote a "transition from an institution and coercion-based, biomedical model of mental health towards a community-based and recovery-oriented model based on consent" (Mijatovic, 2021).

On the other hand, we can find part of institutional psychiatry that advocates maintaining a biomedical perspective. Their main argument is that, because recovery is a multidimensional process, personal recovery construct should be considered as an adjunct or complement to clinical recovery (Jacob et al., 2015; Jaiswal et al., 2020; van Weeghel et al., 2019; Yu et al., 2022). On this subject, the scientific literature provides evidence that clinical recovery and personal recovery are not the same and even that these are outcomes that may not be correlated among them for the users, "so research and practice into 'recovery' should make it clear which version is the focus" (Macpherson et al., 2015, p. 5). In the strain among these two perspectives, the one pretending to integrate two types of interventions and the other one that consider these interventions incompatible because they respond to divergent objectives, resistances to paradigm change usually arise.

Standards of Recovery-oriented Care: the CHIME Model

Considering the polysemy of the recovery concept and the difficulties in operationalizing the notion of recovery-oriented care, in 2011, a team from King's College London led by Mary Leamy and Clair Le Boutillier carried out two systematic reviews of the literature to resolve both difficulties. In the first study (Leamy et al., 2011), the authors made a narrative synthesis of 97 previous publications that defined the concept. This allowed them to identify the five key elements of the recovery process. These are: (a) connection with others and with the community, (b) hope and optimism about the future, (c) a positive sense of one's own identity, (d) a meaning and purpose in life, and (e) empowerment. There is currently an international consensus that this model, known as CHIME for the English acronym, is the one that sets the goals of recovery-oriented interventions. It is necessary to keep in mind that these are the variables that should be evaluated if we want to know the efficacy of an intervention aimed at promoting personal recovery, thus replacing the remission of symptoms and functionality as evaluation parameters.

In the second study made by this team (Le Boutillier et al., 2011), the authors conducted a qualitative analysis of 30 international documents that offered guidelines for implementing recovery-oriented practices. In this case, they identified four key aspects that this type of intervention should meet. These are: (a) promoting citizenship (respect for rights, social inclusion, and meaningful occupation), (b) organizational commitment (giving primacy to the needs of people rather than to those of services), (c) supporting personally defined recovery (informed choice, holistic approach, strengths focus), and (d) a therapeutic relationship that fosters collaboration and promotes hope (peer support, shared decisions, etc.).

In the last decade since the CHIME framework proposal was presented, several empirical studies on its usefulness have gradually been published. On one hand, we found literature that concludes that if "the CHIME framework has gained greater relevance, providing an overarching model of consensus for researchers and clinicians" it is because their multifactorial model is appropriate to measure the 'personal recovery' construct (Penas et al., 2020). At the same time, there is some research indicating that CHIME is a useful, comprehensive, conceptual framework to understand what people do in their everyday life to achieve personal recovery, but it is also necessary to take "the role of socially supportive and financially accessible spaces and activities that support the daily work of recovery beyond the context of formal care and service" into account (Piat et al., 2017).

On the contrary, we can also find studies indicating that although the topics of the CHIME framework account for the most of user's experiences, some of them also have meanings for their own experience that require "an expanded conceptualisation of recovery" in which some clinical factors, such as 'Returning to Normality', should also be included (Stuart et al., 2016). Regarding this remark, we can find studies that suggest exactly the opposite relationship. Starting from the recognition that the experience itself is not neutral but depends on the conceptual frameworks that we use to construct the meanings of what we experience, this study concludes that the meaning that users give to the concept of recovery depends on the paradigm from which they think about it, that is, from the hegemonic biomedical model or from the paradigm of recovery-oriented care (Sampietro et al., 2022).

Recovery-oriented Care in Practice: Programs and Projects for Its Implementation

To see how the paradigm shift in mental health care in our country is being put into practice, we can briefly summarize some of the programs and projects that are already implemented in one of the autonomous communities that has started this process, taking Catalonia as an example. In this case, we can find some actions that are in line with the change of model though they had been started before the publication of the 2017 strategic plans, and other initiatives that have been started since the entry into force of these documents. Among the first ones, we can mention:

Individualized Service Plan (ISP)

Program currently aligned with the proposal of WHO's community outreach mental health services (World Health Organization, 2021a). This program was born in 2003 (Generalitat de Catalunya, Departament de Salut, 2003), collected to be deployed in the 2017-2020 Mental Health and Addictions' Director Plan (Generalitat de Catalunya, Departament de Salut, 2017). Based on a sum of diagnostic criteria, material and social conditions, and the need to use care resources, it offers a personal manager to those who access the ISP program, that is, a professional who individually accompanies and helps them to navigate the network of resources, both from the healthcare network and from their community. The accompaniment is done from a community perspective and with shared decision-making.

Mutual Aid Groups in Mental Health program (MAG)

This program is aligned with the model of WHO's peer support groups by and for people with lived experience (World Health Organization, 2019b). MAGs are spaces for listening and comprehending among people who share the same need or difficulty. They are an example of resources that are not linked to the healthcare network, but rather belong to the community. Through the Get Active for Mental Health program (Rojo-Rodes et al., 2019) a pilot project was implemented, something that made it possible to evaluate their functioning, to systematize them, and to create a series of materials to facilitate their constitution and moderation. Since then, these materials currently allow for the implementation of training workshops for MAG moderators, both for users and survivors MAG (Sampietro & Sicilia, 2018) and for family MAG (Caussa & Cordoncillo Acosta, 2018). Currently, MAGs in Catalonia have the material and logistical support of the public administrations, but they are implemented by entities and groups of civil society.

In turn, among the programs and projects that have started since the publication of the 2017 strategic plans, we can mention:

Peer Support Program

It is a program aligned with the model of WHO's one-to-one peer support by and for people with lived experience (World Health Organization, 2019a, 2021c). It is aimed at training and professionalizing people with personal experience in the recovery process, so they can be support agents for other users of mental health services. Since 2018 there has been a framework document for its incorporation as a new professional profile in the portfolio of mental health services in Catalonia (Generalitat de Catalunya, Departament de Salut, 2018). In recent years, various pilot projects for training peer support agents have been carried out and evaluated (Prat Vigué et al., 2022; Rosado-Figuerola et al., 2019; Sánchez-Moscona & Eiroa-Orosa, 2020). In 2022, it was taught for the first time as an accredited university training module (Universitat de Vic, 2022).

Manual for Recovery and Self-management of Well-being

It consists of material aligned with the model of WHO's person-centred recovery planning for mental health and well-being (World

Health Organization, 2019c). It consists of practical materials and a training workshop that allow users of mental health services to develop their own personalized recovery plan, in accordance with their own preferences and values (Sampietro & Gavaldà-Castet, 2018). It was created within the Get Active for Mental Health program, following a mixed-method participatory process with more than 300 participants. The recovery manual set of materials helps to find and teach how to use the strategies and resources that other people used to promote their own well-being, build a life project, avoid relapses, and/or have a crisis plan to overcome eventual relapses. In 2022, the first evaluated pilot workshop is being implemented, with a view to incorporate the materials and the workshop as resources of the community mental health service portfolio.

Advance Decision Planning (ADP)

It consists of materials aligned with the model of WHO's supported decision-making and advance planning (World Health Organization, 2019d). It is a framework document for the implementation of advanced decisions in the field of mental health and addictions in Catalonia (Generalitat de Catalunya, Departament de Salut, 2020). This material was prepared by a working group made up of clinical professionals, bioethics experts, and members of mental health users' organizations and family associations. ADP is a resource that allows people to establish their preferences for care and delegation of responsibilities in the event of possible future relapses or in situations in which their own ability to make decisions is affected. An ADP is developed collaboratively among the person himself, his or her immediate environment (family, friends, etc.) and professional services. Until 2022 there have been no pilot project to evaluate its implementation in Catalonia.

Likewise, these programs and projects have also been accompanied by changes in the training of mental health professionals and in the regional legal framework. In the first case, including experienced experts as trainers in the compulsory education of those who attend the MIR, PIR, and EIR of mental health (future psychiatrists, clinical psychologists, and mental health nurses), in the second case through the reform of the Catalan Civil Code (Decret Llei 19/2021) to adapt it to Law 8/2021 to support people with disabilities in the exercise of their legal capacity and to deepen the changes promoted by this law, especially to encourage the deployment of the figure of personal assistant, which replaces guardianship and curatorship.

The Future of Recovery-oriented Care in Spain: Risks and Resistances to Its Implementation

We have seen the need and opportunity that we currently have in the Spain and in their regions to promote a change in public policies that regulate socio-health care for mental health in order to align them with the current standards of WHO and the legal framework of United Nations human rights. In this context we can also identify, both in our local and international experience, what the risks of distortions of the model are and what resistance to change hinders this transformation. Among the most significant barriers, we can mention four:

'Pilotism'

We could use this name for the tendency of new resources or programs to remain indefinitely at the stage of pilot evaluations or to be for many years to pass before their implementation in the care network. Thus, for example, the SPI program took more than a decade from its birth to its inclusion in the portfolio of mental health services in Catalonia. Likewise, the Peer Support program, after six years of pilots and positive evaluations, still does not have a professional accreditation recognized by the administration or its own budget for implementation. In addition, in the latter case, the evaluations have focused on the people who have been trained as support agents and not on the impact or generation of value that their inclusion in mental health services could have for the community. One of the conclusions of pilot evaluations made in 2019 (Rosado-Figuerola et al., 2019) is still valid today: there is still a long way to go before this professional figure is part of the service portfolio.

Coaptation

Coaptation is about the distortion of the paradigm due to its application with political interests instead of with socio-medical criteria. In this sense, we can learn from the experience of the Anglo-Saxon world, with more than 20 years of implementation of recovery-oriented care. In this context, there is the Recovery in the Bin movement, which reports a neoliberal coaptation of the recovery model. According to this movement, the principles of autonomy and self-determination are applied in a spurious way to be used as a justification to avoid or deny the responsibilities on the part of the services and the administration. This leads to a situation in which the material and social conditions of existence are not taken into account, reducing recovery to a personal matter: "Many of us will never be able to 'recover' living under these intolerable social and economic conditions" (Recovery in the Bin, 2017, p. 1). In our context, for example, a risk is that once the long psychiatric stay has disappeared (Generalitat de Catalunya, 2022), there will not be a housing alternative with a community perspective for those who need it.

Inertia

Inertia occurs when the discourse is changed, but mental health services continue doing, evaluating, and financing more or less 'the same as always'. This happens, for example, when there is a try to apply a new model based on the recognition of a universal legal capacity, with respect for the autonomy and self-determination of people, but involuntary admissions, forced treatment, and coercion are maintained as practices of the psychiatric institution. In the same sense, it is stated that in recovery-oriented care the main objectives are not the control of symptoms or the functional adaptation of a person to society, but in practice these are the variables that continue being evaluated in trial clinics, whether they are sponsored by the industry or by government entities, ignoring the variables of personal recovery, well-being, and project of life. This happens even with the resources specifically born from the recovery-oriented practices, such as the guides and manuals aimed at promoting the elaboration of personalized recovery plans: "Even when these tools are not aimed to promote clinical recovery, in practice the most disseminated recovery tool is being used in this way." (Sampietro et al., 2022, p. 1)

Boycott

Finally, there is also the position of part of psychiatry, represented by the editorial published by Paul Appelbaum in the journal of the World Psychiatric Association. Appelbaum is an authoritative voice, who had been the president of the American Psychiatric Association (2002-2003 period) and is still a member of the Standing Committee on Ethics of the World Psychiatric Association. Through the loudspeaker of this journal, he called for a boycott of the Convention on the Rights of Persons with Disabilities, which he defines as "a problem child of international human rights law" (Appelbaum, 2019, p. 1). What this sector of psychiatry opposes is especially article 12, of equal recognition before the law. What he considers

unacceptable is that people "unwilling to accept management of their finances, health, or living situations by a guardian, could not be compelled to do so" (Appelbaum, 2019, p. 1). In our local context, a similar position has led to the framework document for the implementation of ADP in Catalonia still not being officially made public, being currently a text that circulates unofficially on the network, a waste of time that would be needed to advance, at least in the information phase. What generates resistance is that the document acknowledges the right of every person to develop an ADP in mental health without the need to previously approve an external evaluation of their ability to decide.

Conclusions

As conclusions of the previous reflections, we can highlight that, if public mental health policies want to go beyond the declaration of good intentions, in order to translate strategic plans into the effective practice of recovery-oriented care, it will be necessary to promote deeper structural changes. It is not only necessary to implement and evaluate new programs and projects, but also to incorporate new resources (even beyond the professional care network), new professional figures, and new care roles to redefine the therapeutic relationship and to make legislative/regulatory changes to guarantee the respect for the citizenship rights of users of mental health services. In this sense, we can learn from the accumulated experience of countries that have been implementing these public policies for years. As a recent review of the literature observed: "Changes in legislation, the development of a national framework, and increased research opportunities and funding are important preconditions to pave the way for a paradigm shift within a country's mental health care system" (Pincus et al., 2016, p. 6).

Finally, we also think that beyond the barriers and resistance, recovery-oriented and rights-based care is here to stay. It is the path marked by all the international organizations that regulate both mental health care practices and the legal framework of human rights. This paradigm shift is proving to be of great value in the countries and regions that are already applying it, and it is also the path that has been started in various regions of our country. In order for us to make this journey without repeating historical or current mistakes, collaboration among all the agents involved and having the voice of the people to whom public policies are addressed are essential. Recovery-oriented care and how we must apply it are both based on the maxim of the independent living movement: "Nothing about us, without us."

Conflict of Interest

The authors of this article declare no conflict of interest.

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