Recovery, non-profit organisations and mental health services: ‘Hit and miss’ or ‘dump and run’?

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Abstract

Background: The evolution of Recovery-oriented mental health services in Western nations across the globe has given rise to a growth in community-based psychosocial support services, to assist in meeting the diverse needs of consumers. This article reports findings of research that explored the perceptions of community workers who are employed by non-profit organisations and deliver psychosocial support services to support delivery of Recovery-oriented clinical mental health services.

Aims: The focus of the research reported in this article includes the benefits and challenges encountered by the community workers when working with clinicians.

Method: The research was undertaken as part of a single-case embedded study, which evaluated the implementation of Recovery-oriented approaches to the delivery of clinical mental health services in a major urban centre located in south-eastern Australia.

Results: Generally, community workers employed by the non-profit organisations perceived the implementation of Recovery-oriented clinical mental health services to be a positive step forward for consumers. Challenges to the delivery of Recovery-oriented services included issues arising from the many different understandings of what it means to experience mental health Recovery, the quality of communication between the community workers and clinicians and the clinicians’ lack of understanding of the role of non-profit organisations and community workers.

Conclusion: The article concludes with recommendations to address the challenges involved, with a view to improving the partnerships between community workers and clinicians, and the Recovery journey of people with serious mental illness.

Keywords
Recovery-oriented services, non-profit organisation, community-managed organisation, community workers, serious mental illness

Introduction

The philosophy of consumer-centred Recovery now frames the delivery of mental health services in Western countries across the globe (Hungerford, 2014). The development of this philosophy has led to considerable change to the way in which clinical services are managed (Kuijpers, Joosten, & de Natris, 2012), as well as a growth in the delivery of community-based psychosocial support services, to meet the diverse needs of consumers (Rosenberg, 2011). This article describes research that explored the perceptions of community workers who are employed by non-profit organisations (NPOs) and deliver community-based psychosocial support services in a large urban centre in south-eastern Australia. These community workers deliver services in collaboration with clinicians who provide Recovery-oriented mental healthcare to people with serious mental illness. The aim of the research was to identify the benefits and challenges encountered by the community workers when collaborating...
with clinicians to support delivery of Recovery-oriented mental health services.

Background
Consumer-centred Recovery for people with mental illness is informed by the concepts of hope, optimism, empowerment and self-determination (Brown, 2012; Slade, Adams, & O’Hagan, 2012). The abstract nature of consumer-centred Recovery suggests some difficulty in deriving a concrete definition – for example, a major focus of Recovery is the personal journey of mental health consumers, with Recovery-oriented approaches to delivering healthcare an important means of supporting consumers to build on their strengths and thereby optimise their potential to live life to the full (Conlon, Bush, Ariyaratnam, Brennan, & Owtram, 2015; Cromar-Hayes & Chandley, 2015).

The development of Recovery-oriented clinical mental health services has occurred in a range of Western health contexts, including those located in Australia, Canada, the United Kingdom and United States (Hungerford, 2014). Recovery-oriented services are characterised by an integration of the concepts of Recovery into the way in which healthcare is provided (Cromar-Hayes & Chandley, 2015; Gomi, Starnino, & Canda, 2014; Piat, Sabetti, & Bloom, 2010; Ramon, Healy, & Renouf, 2007). This evolution – even revolution – in the way in which services are delivered has required a re-thinking of the more conventional biomedical approaches to providing treatment and monitoring symptoms, giving rise to the development and integration of the psychosocial services delivered by NPOs (Hoy, 2014). In this context, the term ‘psychosocial services’ refers to the services delivered to support an individual to manage the social factors that affect his or her mind or behaviours, as well as the interrelationship of these factors (Martikainen, Bartley, & Lahelma, 2002).

The services offered by NPOs in Australia generally, when considered in light of the World Health Organization (WHO, 2009) pyramid for an optimal mix of services for mental health, fall into the categories of primary care services, unpaid carers and (supported) self-care. Determining which services are offered to consumers will depend upon the needs and preferences of the consumers (Bateman & Smith, 2011). Australian NPOs are funded by a mix of government grants, community volunteer fund-raising activities and/or other philanthropic sources (Community Mental Health Australia, 2012; Koehn, Jarvis, Sandhra, Bains, & Addison, 2014; Rose, Cama, Brener, & Treloar, 2013), with the services delivered viewed as complementary to those provided by clinical mental health service organisations. Ideally, the NPOs work together with clinical health service organisations, which provide acute and specialised medical treatment, to improve the consumers’ capacity(ies) to self-determine as well as their levels of mental health and social inclusion (Brown, 2012). In addition, NPOs offer housing support, vocational training and/or education and employment support (Bateman & Smith, 2011).

There is considerable potential, then, for NPOs to make a difference in the Recovery journey of people with complex health conditions or disability (Bateman & Smith, 2011). Even so, more work is required, first, to up-skill community workers; second, to develop the services delivered by NPOs; and finally, to measure the effectiveness of these services (Brener, Grenville, Treloar, Cama, & Whiticker, 2014; Rosenberg, 2011; Williams, Smith, & Lumbus, 2014). Of particular note is the need to build a rigorous research evidence base that demonstrates the worth of these services. For example, and as indicated by a review of the literature undertaken for this study (see Table 1), there is only a small body of research related to the work of NPOs or similar community-based organisations that deliver psychosocial services to people with serious mental illness.

Results of the literature search also show the need to distil a common definition for the organisations that deliver psychosocial services to people with serious mental illness. For example, Table 1 lists the names used to describe organisations that provide Recovery-oriented psychosocial services to consumers and/or unpaid carers. These names include ‘consumer run organisation’ (most common), followed by ‘non-government organisation’, ‘community managed organisation’ and ‘non-profit organisation’, respectively. Agreement upon nomenclature, including definitions and differentiations, is crucial – not only to gauge the effectiveness of the services delivered but also to enable the development of evidence-based recommendations to improve these services. The research described in this article represents a preliminary step towards addressing these issues.

Method
The study was undertaken in a major urban centre in south-eastern Australia, with a population of 350,000 people. The government-funded organisation that delivers clinical mental health services in this location is a part of Australia’s system of universal healthcare and includes four tertiary-level inpatient facilities – providing healthcare that moves through the continuum of treatment, from acute through to rehabilitation – and a comprehensive range of community-based clinical mental health services and clinics for consumers aged across the life-span. Staffing of these clinical services includes medical practitioners, mental health nurses, allied health professionals and technical officers – in this article, referred to as ‘clinicians’.

In line with national policy directives that promote the incorporation of Recovery models of healthcare into government-funded clinical mental health services delivered...
This particular type of case study supports the hypothetical differentiation of specific practices, events or settings into discrete components or ‘units’ that enable the analysis of multifaceted contexts (Yin, 1994/2009). The single-case embedded study allows for each of the units of study to be considered separately in the first instance. Upon completion of all units of analysis, findings are considered cumulatively, including the way in which each aspect of the context affects the other, with this final synthesis providing a more comprehensive explanation of the phenomenon under investigation. Because the findings have been derived from a case study, they are viewed as transferable to other similar contexts or settings and useful for building and testing theory related to the practice(s) or event(s) under investigation (Eisenhardt & Graebner, 2007).

For this project, there was a total of six units of significance (see Table 2), with each generating its own complex data set(s). The final unit, which is the focus of this article, was added to the original project in response to feedback provided by consumers during the fourth unit of analysis.

**Participants**

The research participants were employees of NPOs who delivered community-based psychosocial services to people with serious mental illness. In line with the definition of psychosocial services provided in an earlier section of this article, the services included those that support consumers to manage the social and inter-relational factors that affect their capacity to live independently in the community, including food, employment, housing, as well as social and community interactions. These services were viewed as complementary to the treatment provided by the clinicians who delivered clinical mental health services to the consumers.

The NPO workforce is unregulated, and the community workers have vocational rather than tertiary-level qualifications. It is also important to note that there is currently no standard way of educating community workers about Recovery-oriented practices across the NPOs – a situation that requires further consideration by policy-makers and managers, as well as researchers.

A snowballing approach was used to recruit participants (Browne, 2005) – that is, the first participant was recruited by word-of-mouth, with this participant then referring other potential participants, with the process of recommendation continuing until data saturation was achieved. The same semi-structured interview schedule was employed to guide each of the focus groups discussions, supporting internal consistency by decreasing the possibility of interviewer bias and increasing the likelihood of inter-group comparability (Liamputtong, 2011). The open-ended questions utilised (see Table 3), enabled participants to share their experiences of working with or alongside clinicians to deliver Recovery-oriented mental health services.

Focus group interviews were digitally recorded, transcribed verbatim, and analysed independently by two of the researchers, by coding the data and inducing major themes and concepts from the frequent, dominant, or significant patterns evident in the data (Braun & Clarke, 2006). Such an approach to analysis enabled the researchers to consider how participants made sense of their world and organise this sense-making into themes or patterns. Findings derived by the two researchers were then compared to support achievement of analytical validity.
Ethical issues

The design and progress of the evaluation were informed by consumer and carer representatives from its inception and duration, as is appropriate for research related to consumer-centred approaches such as Recovery (Banfield, Barney, Griffiths, & Christensen, 2014). Approval to undertake the research was obtained from the human ethics committee attached to the local university (Project Number 13-02), with amended approval sought and obtained for this additional unit of analysis. Approval was also obtained from the relevant managers of each of the participating NPOs. Potential participants were provided with the Participant Information Sheet, which included an explanation of the participants’ right to withdraw from participating in the research at any time, and the possibility that findings would be included in de-identified publications in the future. Written consent to participate was obtained from each of the participants prior to assessment of the focus group discussions.

Results

Focus group discussions involved the community workers who were currently employed by NPOs and included a total of 15 (N=15) participants. Four focus group discussions were held, with the average length of the interviews 60 minutes. The length of time participants had been working for the NPOs ranged from 12 months to over 10 years.

Findings generated from analysis of the data suggest that the participants understood the principles and practice of Recovery for people with serious mental illness, with Recovery commonly linked to the notions of ‘hope’, ‘journey’, ‘a unique process’, ‘empowerment for consumers’, ‘building a positive life’, ‘flexibility’ and ‘creativity’. This suggestion aligns with the description of consumer-centred Recovery provided in an earlier section of this article. Participants also expressed the opinion that they, as community workers employed by NPOs, made a substantial difference to the lives of their consumers by practising the principles of Recovery.

Participants then went on to consider the implementation of Recovery-oriented services by the organisation that...
delivers the clinical mental health services. Analysis of the data identified two main themes, ‘Benefits’ and ‘Challenges’, with each of the themes comprising a number of sub-themes. These major and sub-themes are explored in turn in the following sections, which includes extracts from the interview transcripts to illustrate salient points (see Tables 4 and 5).

Benefits

A common aim. All participants – that is, community workers employed by the NPOs – saw great value in the implementation of Recovery-oriented services by the organisation that delivers clinical mental health services (see Table 4). The shared aims of the community workers and clinicians, including the delivery of consumer-centred care to people with mental illness, meant there was a common understanding of goals between all those involved, including consumers. For example, the participants suggested that the shared focus on hope, optimism, choice and self-determination had led to greater levels of consistency in the way consumers were supported. A common aim meant that all stakeholders were headed in the same direction.

Positive outcomes. The community worker participants also suggested that the relationships, formed at the service levels between the community workers and clinicians, and evidenced through the generally better collaboration to deliver services, had led to a number of improved outcomes for consumers. Of particular note were the perceived benefits for consumers that resulted from the shared focus on hope, optimism, choice and self-determination. These benefits included a greater level of consumer involvement in decision-making, improved understanding of goals between all those involved, and a more holistic approach to service delivery.

Challenges

Alongside the perceived benefits derived from the implementation of Recovery-oriented clinical mental health services, participants also identified a number of challenges. These challenges, which included perceived differences in the way in which the community workers and clinicians approached the delivery of services, are now discussed in turn.

Different understandings of recovery. The community worker participants observed that, while the NPOs and clinical health service organisation both framed Recovery-oriented services as consumer-centred and optimistic, there were nevertheless differences in the way these Recovery-oriented services operated in practice. For example, participants reported that many clinicians, while advocating for mental health Recovery, continued to take a paternalistic approach to delivering healthcare. This included clinicians writing the consumers’ Recovery plans, or informing consumers of what their personal preferences or goals ‘should’ be, with many of these ‘shoulds’ a product of the mainstream, middle-class demographic to which the clinician, rather than the consumer, belonged (see Table 5). In contrast, it was the view of the participants that many consumers had quite different ideas of what it meant to live a meaningful life. According to the participants, these differences created difficulties for the consumers and clinicians alike, especially when clinicians used these ideas – including the values that frame them – to gauge a consumer’s level of wellness. Ultimately, the problems generated by these differences impacted detrimentally upon consumers and their perceptions of their Recovery journey.

Different approaches to supporting recovery. The community worker participants also noted the apparent difficulties faced by clinicians when supporting Recovery for consumers, due to the perceived bureaucratic requirements of the government-funded health service organisation. These bureaucratic requirements included the many different processes related to clinical governance – for example, clinicians were required to use a Recovery Plan that condensed the personal journey of the consumer to a set of tick boxes. Regular 3-monthly reviews of this Recovery Plan were also required by the health services organisation, with such frequent reviews reportedly causing some distress for consumers with chronic and complex experiences of mental illness.

At the same time, the participants commented on the high caseloads of clinicians, which perhaps explained the perceived ‘dump and run’ mentality exhibited by some services (see Table 5). For example, it was reported that when consumers were transported to the NPO settings, post-discharge from hospital, they were handed over with little or no sharing of information – apart from the instruction to contact the clinician only if there was a problem. No explanation of the nature of such problems was forthcoming from the clinicians.
Indeed, a major issue for all participants related to information sharing. Generally, participants noted issues post-discharge from the hospital and also after case reviews, with clinicians failing to pass on information that would be important to enable a more effective delivery of psychosocial services to the consumer. In addition, when participants shared their insights with clinicians regarding a consumer’s progress in his or her Recovery journey, or advocated to clinicians on behalf of the consumer in relation to a particular choice or preference, participants felt that their feedback was dismissed. One reason for this was identified as the lack of tertiary qualifications held by the community workers – with this situation perceived as creating a hierarchical divide between community workers and clinicians. The exception to this was the one NPO with a formal agreement in place with the mental health service, where communication channels were described as excellent.

Challenges to relationships between community workers and clinicians. The community worker participants were
Our lives; it has to change according to the needs and basically the demands of life’. (Focus Group 2)

‘… time you need flexibility and choice that is adaptable to individual people … It cannot work the same for the rest of their life, or … this recovery plan with specific boxes that you need to complete, it’s challenging because you need a system, but at the same time I’ve been educated by the clinicians about [something] that may not be possible and [so I] might have to accept that for the person. So I’ve needed to be tempered a bit as well in my perspective’. (Focus Group 1)

‘… there’s a few clinicians that I would speak really highly of, and I think do a really good job, if you can build a rapport with them …’ (Focus Group 1)

‘… I feel recovery is constantly changing. Everyone’s in recovery for something. Like you can’t just say, “Here’s your recovery plan, we’ll check it out in three months, or six months, or whatever.” I just don’t think it works like that, you can’t just write things down and go, “Yeah, check that out.”’ (Focus Group 2)

Table 5. Challenges of Recovery-oriented services: identified themes by community workers in focus group discussions.

**Challenges**

**Different understandings of Recovery**

‘We have a recovery plan which is written by clinicians [when] our participants were not present … (or) a clinician will tell me, “Okay, I’ll do a recovery plan and let you know.” But I see it differently. The recovery plan is not mine, the recovery plan is not the clinician’s, [the recovery plan] is for a consumer that we actually work with!’ (Focus Group 1)

‘… it also depends on the clinician if they’ve a medical background, because a lot of people that have been clinicians for many, many years still think in terms of recovery only through [medication] … they don’t really see the fullest perspective of what recovery can mean to people.’ (Focus Group 1)

‘I came in with a view of recovery that has lots of possibilities, and I still hold that for people. [But] I think probably that’s … one of the things that I come up against fairly regularly – the vision that a clinician might hold for someone and what I hold for someone can be quite different. [But] I think I’ve been tempered a little bit. It’s challenging to have my ideas of where someone might be able to go in their recovery kind of squashed, or seen as childish, or not possible, so that’s been interesting to sort of play around with that. At the same time I’ve been educated by the clinicians about [something] that may not be possible and [so I] might have to accept that for the person. So I’ve needed to be tempered a bit as well in my perspective’. (Focus Group 1)

‘… at discharge which is a critical point, someone might have [a NPO community worker] … for 18 months or a year. The worker is not even told that they’re discharged, like a family member may not be told’. (Focus Group 1)

‘… it’s, like, “Well, I think this is what’s wrong, and this is what you should do” and no-one’s asking the consumer, “Well what do you think? You know what it’s like?” And I don’t really like the word “recovery” either … [instead, we could ask] “Where do you want to be in your life? What would make you happy? I mean if you’re happy to listen to voices, and you’re not scared … and you’re not hurting anyone, then that’s all right.”’ (Focus Group 2)

**Different approaches to supporting Recovery**

‘… there is a picture coming from above that recovery means integrating people … into the mainstream community. But the reality is that our client base actually has a community here … that’s not necessarily connected [to] traditional ways with nine to five jobs, and mortgages, and … white picket fences … things the mainstream community seems to think everyone is aiming for …’ (Focus Group 2)

‘… You either fit into these streams, or you don’t fit. And more of our clients fit into that than not fit [a category] … so that particular sense of recovery means there’s something wrong with you, that you need to “recover” from it. But what if you’re quite happy in the person that you are?’ (Focus Group 2)

‘… it is from the outside, clinical managers seem unbelievably overworked, they seem overstretched, they seem to have too many people on their case load. Every mental health team I’ve come across, every clinical manager I’ve come across … I think the burnout rate is going to be over the top. I don’t know how they can expect people to work under those conditions … It’s ridiculous. How can they do what they’ve been trained to do – it must be so frustrating for them not to be able to practise in the way they want to practise because they have way too many on their case load’. (Focus Group 1)

‘Well it’s the pointy end still, like we’re still looking at people at the bottom of the cliff rather than people at the top. If consumers were [truly] driving this, they would be able to ring our service and say, “Look, I’m not travelling so well, if I could just get your help for four weeks.” We could say, “Yes, let’s organise a clinical manager for you for that period and we will work with you.” And that would be a great intervention rather than that person getting to the point of being so unwell that they end up in the mental health assessment unit, they’re transferred to [the acute unit] if they’re lucky to get a bed, but it has to get to that point. So we’re saying that a service like ours would be very usefully utilised for early intervention’. (Focus Group 1)

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Challenges

‘… this comes back to your bureaucracy thing, “No, that ain’t in my box, it’s not my job, I don’t deal with that.” Well people are complex and big, and there’s lots of stuff going on that doesn’t necessarily fit neatly into one section’. (Focus Group 2)

Challenges to relationships between community workers and clinicians

‘… engagement between non-government organisations (and the health service) is quite hit and miss’. (Focus Group 1)

‘We’re supposed to work in partnership to be on the same side but sometimes I have the feeling that we are on another side’. (Focus Group 1)

‘We’ve absolutely had to face off and have difficult conversations and managed the interactions that can be quite [challenging?] … there could be attitude coming from both sides. We have to work at our attitude and our listening up and their listening up to us, so we’ve actually had to relate, we’ve had to learn to relate. And at the director level that’s been very difficult and we’ve had to learn to do that at the director level, and that was really obvious that it was like … we want to be respected in terms of the work that we’re providing in the community, but we weren’t getting the respect. It was not in the picture, so that was something we had to keep working at, keep fronting up, keep sort of … standing up for that, keep saying what we’re doing, chipping away, chipping away and then just recently that’s sort of like … phew, we’ve actually got to something in terms of that relationship’. (Focus Group 1)

‘[You may find] one clinician and work with them, and they would have a recovery plan for somebody. They’d give that to you, they’d do regular [Life Skills Profiles], and give those to you … And then you’d have another three clinicians who would say to you, “A recovery … what?!” … They’ve never even seen [a recovery plan]! Or you’ll ask them [for a recovery plan] and they’ll say, “Yeah, I’ll send that to you” and six months later you’ve asked 50 times, you’ve sent a hundred emails, you’ve rung them, you’ve begged, you’ve pleaded, you’ve grovelled in the dirt … and you just don’t get anything …’ (Focus Group 2)

‘[There is a] challenge between building individual relationships and service relationships. Individual relationships we’ve found easy to build, or certainly in my experience; you know, you find a good clinician, you’re working with a [long term] consumer, you can build good relationships. But the service relationship is more challenging to build, which is a problem because if the system is working it shouldn’t matter who’s delivering [the services]’. (Focus Group 2)

‘It’s really good when it’s good, but my experience generally with a lot of the [clinicians], is that there is a] high turnover … With one of our clients, who I’ve been working with for a year, we had the same psychiatrist and clinical manager for the whole year … and there was a really strong sense of collaboration, and there’s been, well, fairly good improvements for the client actually, so I found it very consistent. But that’s just, yeah, with one client’. (Focus Group 2)

‘It’s a bit of hit and miss. But if [we] keep up the communication, keep up the pushing of it, it [does] happen. Since [the implementation of Recovery-oriented services] there’s been a shift … By really trying to push and work collaboratively, it does work with individual [clinicians]’. (Focus Group 3)

‘And also even, you know I’ve personally done a lot of promoting our service to the public health services, like I’ve gone out and spoken to the regional deliverers … and interfaced and said, “This is what our service is,” but I still meet plenty of clinicians within the public health service that wouldn’t have a clue that we exist – any of our services’. (Focus Group 2)

‘Because the other month the clinician came down. He said, “I’m worried about the client … [attempted suicide] … because he’s fed up at seeing all these visions, terrible visions.” He said, “I’ll go back and talk to his psych, see about changing his medication.” I said, “Okay, keep me informed what’s going on.” Not a word. I sent two emails saying, “What is going on?” He never got back to me. Yeah’. (Focus Group 2)

‘I’ve seen that problem with many health professionals. You keep emailing them, keep asking them questions, but there is never an answer’. (Focus Group 2)

Lack of understanding of the community workers’ role

‘… we want to be respected in terms of the work that we’re providing in the community’. (Focus Group 1)

‘I also wanted to point out that if they say we’re going to work together, they should treat us as equal. I don’t feel that they treat the community sector workers as something on their level; they think we are inferior to them. Yeah. Because maybe they have more clinical knowledge than us, but I don’t know about their other knowledge in other areas, because I’ve seen them, sometimes they talk rudely, or sometimes they don’t know how to talk, or how to approach, and they try to avoid the situation … So I’ve had this feeling that they don’t treat the community sector workers as something important’. (Focus Group 2)

‘[The clinicians] just seem to treat us like we’re a bit extra, that we are not qualified or anything. We’re just there to hold people’s hands while they do their bit, and we are just … [pause] … Yet we are the ones who see [our clients] on a regular basis … and we can pass on some very important information to them, but we basically get, “No, you’re just case workers.” It’s like a qualification snobbery hierarchy’. (Focus Group 2)

‘I still … come across pockets of one or two, more so with higher level health professionals who may see us as more like … We’re not seen as clinicians, and we’re not seen as being a major player or stakeholder, we’re more or less maybe a transport service … And that’s one thing we’re trying to change, is some doctors have seen us as a transport service, to pick them up and drop them off for medical visits or so forth. So we’re trying to say, “No, we’re more than that.”’ (Focus Group 3)

‘We are mental health recovery workers, here to provide a service and a Recovery-oriented approach. We are not just a taxi’. (Focus Group 3)

‘I have had other colleagues here say they’ve wanted medication reviews for their clients and the doctors pretty much brush[ed] them off because they think we’re just support workers’. (Focus Group 4)
Clinicians’ lack of understanding of the role of community workers. The majority of community worker participants commented on the apparent lack of understanding of clinicians of the role of NPOs and/or community workers in general, especially in relation to consumers and their Recovery journey. A common perception was that clinicians saw community workers as little more than a taxi-service (see Table 5), always available to drive consumers to appointments with medical practitioners or case workers. Hand-in-hand with this perception was the lack of respect exhibited by some clinicians – medical practitioners, mental health nurses, and allied health professionals alike – towards the community workers. This was evidenced through a dismissing of the work of community workers due to their lack of tertiary-level qualifications (already noted). The perceived lack of respect led to problems for the consumers when the community workers fed back information to the clinicians about (for example) a change in a consumer’s symptoms of mental illness or side-effects to medications.

Such attitudes from the clinicians were also viewed by the participants as undermining of the Recovery journey of the consumers. This is because the information that the community workers were keen to share with the clinicians was derived from observations made from the considerable amount of time spent with the consumers – in contrast to the relatively small amount of time spent with the consumers by clinicians. Such information was also viewed as potentially useful for clinicians to provide more effective clinical interventions for consumers and, subsequently, achieve better outcomes for consumers.

Discussion

Findings from this study are important for identifying the issues for community workers, together with the clinicians with whom they collaborate, to provide psychosocial care to people with serious mental illness. A number of benefits for consumers that result from the collaboration between NPOs and the clinical health services organisation were flagged by the participants, and included an improvement in outcomes for consumers. At the same time however, many challenges were identified, including the ‘hit and miss’ and ‘drop and run’ nature of the relationships between community workers clinicians. Perhaps of most concern were, first, the perceived poor attitudes of some clinicians towards the contribution made by community workers in supporting the Recovery journey of the consumers; and, second, the perceptions of marginalisation that these attitudes produced in the community workers.

The perceptions of marginalisation experienced by the community workers are supported by findings of other units comprising the larger single-embedded case study. Specifically, the key role played by community workers and NPOs in supporting the delivery of Recovery-oriented services was not identified by clinicians nor by carers. In contrast, the consumers highlighted the centrality of the NPOs and community workers in supporting their journey to Recovery (Hungerford & Fox, 2014). There are major differences between the perceptions of clinicians and carers, and the perceptions of consumers and community workers. This finding points to the need for improvements in the way in which all stakeholders communicate and collaborate to support consumers.

Solutions to the issues identified

The formal agreement that has been established between one NPO and the organisation that delivers clinical mental health services had, in the view of the community workers, substantially improved the quality of professional relationships and also the sharing of information. Such agreements could likewise provide a clear step forward for services who may be seeking to improve the partnerships between these key stakeholders. Systematic change is always preferable to reliance upon the goodwill of individuals who are likely to move on to other positions – or, at worst, burn out from heavy caseloads (Keogh, 2014). Well-implemented formal agreements, which strongly support the exchange of information across the continuum of care, are therefore an important means of achieving change.

More challenging is the need to address variations in the practical application of Recovery, which arise from the institutional and socio-cultural differences of the diverse organisations that deliver mental health services. For example, and as noted by Hungerford (2014), there are many difficulties associated with the process of implementing...
consumer-centred models, including Recovery-oriented approaches, into government run health services organisations with a strong clinical focus. Likewise, the background section of this article shows that community-managed organisations such as NPOs, consumer-run organisations or NGOs can have diverse aims, structures and staffing profiles. Adding to this complexity, findings reported in this article point to the influence of the values of individual community workers and clinicians upon the way in which Recovery-oriented services are operationalised. For example, community workers observed that most clinicians lived according to the dominant Western socio-cultural paradigm – characterised by relatively high levels of education, employment, owning a car and home and regular holidays and made the presumption that others aspired to live likewise. According to the community workers, however, a meaningful and contributing life has many different manifestations, and to force one particular way lifestyle onto all people, including consumers of mental health services, is not useful. There is a need, then, for all those involved with the delivery of consumer-centred Recovery-oriented services to examine their presumptions or preconceptions and reflect upon the many different ways in which people find meaning.

Clinical implications

The increased emphasis on incorporating the principles of consumer-centred Recovery into mental health services across the Western world has seen marked changes in the way in which these services are delivered. This has led to an increased focus on the psychosocial services delivered by NPOs. Findings from this study suggest a number of ways in which the effectiveness of these services can be achieved.

First, when clinical health service organisations and NPOs work together to support consumers, positive outcomes for the consumer can be achieved. Formalisation of the co-operation between these organisations with Memoranda of Understanding can provide a useful way forward, with such documents providing the structure and organisational validation that enables this collaboration. There is also a need for clinicians, even those with onerous workloads, to make the time to share information with, as well as talk to community workers in a respectful and open way. Such an investment of time has the capacity to lead to better outcomes, particularly in relation to supporting the Recovery journey of consumers.

Second, clinicians are encouraged to challenge themselves in relation to the way in which their understanding of Recovery is framed – or limited – by their personal and socio-cultural demographic, together with their related worldviews. Notions of ‘should’ are rarely helpful when supporting others, particularly when they relate to personal value and notions of what it is that makes a life meaningful. The journeys of consumers towards mental health Recovery are inherently diverse – however, the bureaucratic requirements of the government-funded organisations that deliver mental health services tends to work against such diversity. This raises the questions of how clinicians can support the central tenets of consumer-centred Recovery, when working within a system that focuses on the biomedical concerns of the consumer. Resolving the ambiguities requires wisdom and also flexibility. Exploring ways and means of overcoming these challenges is a work-in-progress and future research.

Conclusion

Findings of the research reported in this article show that there has been some progress in the way in which Recovery-oriented mental health services for people with serious mental illness are delivered – as well as progress in building a research evidence base to support this progress. Even so, challenges to the communication between clinicians, community workers and consumers mean that the Recovery journey of consumers can often be inhibited. Communication is the key to resolving such challenges – with clear, open and meaningful dialogue between consumers, community workers and clinician enabling the delivery of Recovery-oriented services. It is important, then, that all stakeholders persevere to develop positive working arrangements, including the formalising of the partnerships, where ever possible. Recognition of the important role of community workers and services provided by NPOs cannot be underestimated by clinicians. It is only with due acknowledgement that NPOs and community workers will continue to play a crucial role in supporting the Recovery journey of consumers through the formation of strong collaborative partnerships that support consumers to achieve the best possible outcomes.

Acknowledgements

The authors wish to thank Carmel Davies for assisting with the preparation of this manuscript.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

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