Using sustained recovery and relapse prevention in mental health

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In this article...
● Concepts of recovery and relapse prevention in mental health
● The Brent model of Sustaining Recovery and Relapse Prevention
● Service users’ experience using this model of care

Key points
- Mental health rehabilitation is inspired by the relapse prevention and recovery models
- The recovery model emphasises the rooting of new meanings and purpose in one’s life
- Relapse prevention is key in helping service users achieve sustained recovery
- The Brent model of sustained recovery trains service users to identify and avoid factors that can lead to relapse

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Abstract In mental health care, the recovery model emphasises the rooting of new meanings and purpose in one’s life to move beyond the effects of mental illness. However, mental health service users also need strategies to ensure their recovery is sustainable in the long term. In trying to find a solution to the issue of sustainability, a group of mental health professionals working in Brent has designed an approach that blends the principles of recovery and relapse prevention. This article describes the model, its conceptual background and benefits.


While recovery is the initial priority for mental health service users, it is also important that this recovery is sustained. Clinicians working in mental health services in the London borough of Brent have developed a model of rehabilitation through which service users learn to cope with their condition, find new hope and meaning, avoid relapse and grow stronger from their experiences.

The model, Sustaining Recovery and Relapse Prevention (SRRP), combines recovery and relapse prevention approaches. This article discusses its conceptual background and describes what the training entails, using the personal testimony of a service user to highlight the benefits of the approach.

Conceptual background Recovery and relapse prevention
Recovery, an increasingly popular concept in mental health (Slade et al, 2012), has been described as:
“a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself.” (Anthony, 1993)

The term ‘relapse prevention’ was coined by Marlatt and Gordon in the context of treating addictive behaviours. They defined it as “a self-management programme designed to enhance the maintenance stage of the habit–change process” (Marlatt and Gordon, 1985). Marlatt (1996) described the approach as a transitional process, a series of events that may or may not be followed by a return to baseline levels of the target behaviour.

The recovery model emphasises the development of new meanings and purpose in service users’ lives to help them move beyond the catastrophic effects of mental illness. The underpinning...
principle is that they can be supported to live ‘normal’ lifestyles and undertake activities (such as interacting with family and friends, going into education or work, pursuing hobbies, contributing to the community, developing intimate relationships and expressing spirituality), despite episodes of illness. However, the model does not address sufficiently how improvement can be sustained. From our clinical experience and the experience of the service users and carers with whom we work, we know more emphasis has to be placed on interventions to prevent relapse and sustain recovery (Jumnoodo and Coyne, 2011; Foster and Jumnoodo, 2008; Jumnoodo et al, 2003, 2001).

An integrated approach

The ‘relapse prevention’ and ‘recovery’ models have both influenced mental health rehabilitation work. Through them, the notions of ‘hope’ and ‘engagement’ have been adopted as key indicators of sustained recovery. In an integrated approach, ‘recovery and relapse prevention’ can be defined as the art of taking control of one’s life and regaining hope through the acquisition of knowledge, skills and experience, allowing one to grow stronger through cycles of change.

The Brent model

From our experience in Brent, service users and their carers benefit most from the recovery approach when it is linked to a well-tested relapse prevention model (Mueser and Gingerich, 2011). This led us to integrate relapse prevention into recovery plans to develop the Brent model of SRRP – in this model, relapse prevention is key in strengthening the ‘community recovery capital’ of service users in an all-embracing psychotherapeutic approach that is rooted in cognitive behavioural therapy and social learning theory (White and Cloud, 2008). The model aims to help service users maintain a healthy lifestyle with the hope of managing any problems related to their mental illness in their own way.

Box 1. Elements of the SRRP training programme

- **Engagement**: participants are invited to make a conscious decision to engage with the training. Professionals delivering the training have an opportunity to strengthen trainees’ motivation
- **Introduction to SRRP**: the simplicity and helpfulness of the model is highlighted and its effectiveness is illustrated through examples. Participants’ commitment is formalised through a signed agreement
- **Understanding the ideas of lapse and relapse**: this session clarifies that mental health deterioration is seldom an unambiguous, binary process in which people are ‘well’ and then suddenly ‘unwell’. Participants are encouraged to explore possible reasons for their lapses and relapses, and learn about developing tailored SRRP plans to reduce such occurrences and sustain overall wellbeing
- **Identifying high-risk situations**: participants are shown how they can increase their awareness of high-risk situations by mapping potential sources of stress; a tailored SRRP plan can then be developed to avoid stress factors that could lead to relapse
- **Identifying warning signs**: the importance of recognising warning signs as soon as possible is emphasised, as this will prompt early intervention by professionals and minimise disruption to participants’ lives. Warning signs can be, for example, withdrawal from help, increased agitation and irritability, refusal to take medication, sleeplessness, and an urge to consume alcohol or take illegal substances
- **Identifying and managing stress**: exposure to, and inability to cope with, stressful situations increases the risk of relapse. Participants learn about coping strategies and building on their self-efficacy to deal with stressful events
- **Identifying thinking errors/faulty thoughts and learning to manage them**: participants are helped to understand that thinking errors are automatic and often result in distortions of reality that are unsupported by evidence; an example of one such thought could be “I know I’ll die if I take the tablets the psychiatrist gave me”. Participants are encouraged to keep a diary of their thoughts, feelings and resulting behaviours, which serves as a useful tool to self-manage erratic thinking patterns
- **Identifying and exploring the effects of rule violation**: disruptions in one’s health maintenance plan (for example, ceasing to take one’s medication) often lead to relapse fraught with negative emotions (such as feeling guilty or untrustworthy). This session provides a thorough understanding of these processes, which helps participants avoid disruptions and maintain their focus on future health and wellbeing
- **Identifying and exploring lifestyle balance**: this session focuses on participants’ engagement with a range of activities that can help them achieve a more balanced lifestyle, including: exercise; interaction with family, partners and friends; education; hobbies; holidays and exploring spirituality. More practical topics, such as finances and accommodation, can also be part of the plan
- **Devising an SRRP plan**: the final session pulls together all the knowledge acquired in previous sessions, leading to the drawing up of an SRRP plan to reduce lapses and relapses, as well as sustain wellbeing and recovery

SRRP = sustaining recovery and relapse prevention

Service users are introduced to SRRP via a training programme that aims to explain the model in a simple, user-friendly way. It aims to facilitate participants’ engagement and foster their understanding of how recovery and relapse prevention can be interwoven to deliver more sustained outcomes. The programme can be delivered as:

- An open exploratory session – to ensure service users and their families connect with it and understand the potential benefits before making a voluntary decision to engage with future sessions;
  - Individually;
  - Through structured group sessions and work done at home.

The programme can also be adapted (Gillespie, 2015) to cater for the training needs of different groups, such as service users, carers, health professionals and social care professionals. Box 1 details the to subject areas that can be delivered individually or bundled together, depending on service users’ needs and preferences.

For professionals, classroom-based training on SRRP needs to be followed by work-based practice and supervision in action.

Benefits of the approach

To date, a total of 88 participants have undertaken the SRRP training programme; these have included service users, carers and staff members. Most found the approach beneficial and easy to apply in daily life, as illustrated by the following comments:

“*It has made me realise my potential and what things I am capable of doing.*” MJ, service user

“All our service users and staff...
A whole-system approach was adopted (Jumnoonoo et al, 2002), with service users and carers being empowered to lead the programme delivery and draw on their personal experience. In Box 2, a service user explains how the SRRP approach has instilled hope in her life.

We continue to use SRRP to help people with serious and enduring mental illness, and others in contact with mental health services in Brent. Beyond our own setting, we have also supported others in using and developing the model, both for mental and physical health problems – for example, in areas such as medication adherence.

SRRP can be offered to service users – one-to-one or in small groups – through counselling or knowledge and skills training sessions to teach them how to manage their condition and prescribed medications, thereby enabling them to stay well and prevent relapse. This psychosocial model of health maintenance has been acknowledged by the NHS Commissioning Board (2013) as a tool to enhance quality of life in long-term conditions.

Disseminating the model

The SRRP model could have a place as a training and practice framework in the NHS, with benefits for service users, carers and others in contact with mental health services, both for physical and mental health conditions. SRRP training could inspire mental health nurses to help service users rediscover wellbeing and balance, and consider this as one of their core vocational responsibilities and competences (Coombs et al, 2003).

If the SRRP model was widely introduced in nursing to other health professions, a system of supervision and structured levels (from the basics to more advanced levels) would be required. Universities could consider including SRRP training in their undergraduate and postgraduate curricula. Wider uptake would result in a cohort of SRRP experts capable of: further improving the model; providing consultancy to clinicians, service users and carers; and cascading SRRP knowledge where needed.

Conclusion

The SRRP model aims to empower mental health users to regain hope and live their lives despite their illness, with the support of a tailored SRRP plan targeted at avoiding and/or coping with relapse risk factors and high-risk situations. Mental health nurses could benefit from adopting, reviewing and developing the Brent model, and all nurses could benefit from absorbing the model’s discourse, as it enables reflection on practice.

Box 2. A service user’s account

“People used to tell me I have a mental health problem but I do not know anyone who is 100% sane. My first understanding of the term ‘recovery’ was when I had an acute episode of appendicitis, at 16 years of age, with all its active symptoms – high fever, tender abdomen. After having [my appendix] removed, there was a reduction in my symptoms, which did not return.

“However, the term ‘recovery’ did not apply to me when I developed diabetes and schizophrenia. In that case, ‘recovery’, to me, meant an enduring change to cope with such chronic conditions – in other words, managing my life differently, in a hopeful way. The most important thing to me is to preserve my self-esteem, be with my friends and family, fulfil my career ambition of being a psychiatric nurse [...] and not to have the experience of social stigma.

“I have put considerable effort into surrounding myself with people who have similar mental health-related problems to myself. After doing a course of recovery and relapse prevention, I now know that any remission of my illnesses is a step forward to enhance my coping mechanisms. I have had many relapses but, due to the skills I have gained through recovery and relapse prevention, I have been able to address the negative changes at an earlier stage each time. I have now learnt that it is a challenge for me to overcome the pessimistic feelings, thinking and behaviours of my illnesses.

“I have been able to take charge of my life by qualifying as a psychiatric nurse and meet my individual needs and preferences by drawing on my life experiences. How did I do it? By saying and convincing myself that I should be strong, resilient and able to trigger my coping strategies, and by having support from my friends and relatives when I am not well. However, for me to be healthy, I know I will need respect from the community, family, friends and society, as well as my own recognition that the onus of responsibility is mine to overcome barriers that will be presented to me on my journey to recovery.

“I am now involved in several voluntary projects and earning some money. Overall, I get on with my life and am not overly preoccupied with my mental illness. I am coping with my illness problems when they happen and I focus on finding solutions to live my life the way I want. My message to service providers is to equip people like me, people in similar situations to me, with the skills to manage their lives by living with hope, being in charge and being motivated to live like a normal citizen.”