Everyday Solutions for Everyday Problems: How Mental Health Systems Can Support Recovery

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People who experience mental illness can be viewed as either fundamentally different than, or fundamentally like, everyone else in society. Recovery-oriented mental health systems focus on commonality. In practice, this involves an orientation toward supporting everyday solutions for everyday problems rather than providing specialist treatments for mental illness–related problems. This change is evident in relation to help offered with housing, employment, relationships, and spirituality. Interventions may contribute to the process of striving for a life worth living, but they are a means, not an end. Mental health systems that offer treatments in support of an individual's life goals are very different than those that treat patients in their best interests. The strongest contribution of mental health services to recovery is to support everyday solutions to everyday problems. (*Psychiatric Services* 63:702–704, 2012; doi: 10.1176/appi.ps.201100521)

Is it more helpful to view people who experience mental illness as fundamentally different from, or fundamentally similar to, other members of their community? This question underpins a debate currently underway in the United States about the nature of mental health policy (1). Are services for persons with a mental illness best provided within a framework of mainstream public policy or through a mental health–specific policy geared to individuals with exceptional problems?

In a review of a series of articles that argued for a shift toward mainstream policy, the authors identified two conclusions (1). First, understanding the contribution of mental health research to mainstream public policy is in everyone's interest. Second, this shift changes the metrics for evaluating success away from traditional clinical imperatives, such as symptomatology and relapse rates, and toward valued social roles, such as residential stability and labor force participation.

In the United Kingdom, a similar shift toward emphasizing commonality over differences has occurred. Current mental health policy identifies six outcomes to improve mental health: improving physical health, supporting recovery, improving experience of services, reducing avoidable harm, decreasing stigma, and improving the population's well-being (2). This policy has shifted the balance away from a special policy for dealing with mental health problems and toward integration of mental health into mainstream social policy, a change reflected in the policy's title—"No Health Without Mental Health."

The same question that has preoccupied policy makers arises at the level of the individual. Although the question has been explored less at that level, two classes of problems and two classes of solutions can be distinguished. People using mental health services often have both everyday problems of the sort experienced by others in their community and problems specifically related to mental illness, such as symptoms and cognitive difficulties. The challenge for service provision is achieving the right balance between use of the everyday solutions used by others in their community and use of specialist solutions (treatments). The traditional approach, perhaps, has been to prioritize specialist solutions for mental illness–related problems—provide treatment so people can get on with their lives. However, in a recovery-oriented mental health system, the balance changes toward supporting everyday solutions for everyday problems.

A recovery orientation is now central to mental health policy throughout the English-speaking world (3). This Open Forum discusses the practical implications of the change in orientation and describes the scientific evidence underpinning this reorientation (4,5).

An illness or a person?

Development and consolidation of one's identity are central to recovery (6). The construct of identity has emerged from three academic disciplines (5). A sociological understanding of identity emphasizes commonality, the ways in which people are alike. A psychological understanding emphasizes difference, the ways in people are not alike. A philosophical understanding emphasizes permanence, the persistence of identity over time and space.

Mental illness creates a sense of being different than others—of being alone, helpless, tainted, or hopeless.

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Clinical processes that further emphasize difference, such as assessment processes focused on intrapsychic deficits, can inadvertently contribute to the development and maintenance of a stigmatized identity as a mental patient. Indeed, the focus on intrapsychic deficits to the exclusion of intrapsychic strengths, such as artistic skills, and of environmental deficits and strengths, such as poverty and cultural resilience, is a longstanding criticism of the mental health system (7). Supporting recovery involves amplifying commonality and permanence rather than difference and transience. This approach can be summarized as, "Recovery begins when you find someone or something to relate to" (8). The job of the system is to support the relationship and connection with self (permanence) and others (commonality).

Supporting recovery

The central shift in a recovery-oriented system, therefore, involves seeing an individual not as a patient—someone who is fundamentally different and therefore needs treatment before getting on with life—but as a person whose efforts to live the most fulfilling life possible are fundamentally similar to those of people without mental illness (9). What does this shift in focus mean for clinicians?

International best practice in supporting recovery identifies four domains of action: providing treatments to support personally defined recovery, developing a working relationship with the individual, maintaining an organizational commitment to recovery, and promoting citizenship among individuals in recovery (10). This last domain has been the least investigated, and yet, plausibly, it is the most influential. Improving social inclusion and community integration requires clinicians to pay more attention to supporting the person to make connections and to the creation of inclusive communities. As a result, clinicians may have a much wider role than just providing treatments (11).

Practical goals

According to one author, "Social inclusion must come down to somewhere to live, something to do, someone to love. It's as simple—and as complicated—as that" (12). How can clinicians support people to meet housing, employment, and relationship goals?

In many cases, mental health or substance abuse treatment is a precondition for obtaining housing. Yet emerging evidence suggests the everyday solution (housing-first, no precondition, model) leads to greater consumer satisfaction than the specialist solution (supported-housing model) (13). The assumption that being a good tenant should be a requirement for obtaining tenancy has proved unhelpful; for example, the impact of sobriety at program entry on outcome is minimal (14).

For employment, the empirical data are clear—the everyday solution of supporting people to obtain and maintain community-based competitive employment through individual placement and support schemes is more effective than providing noncompetitive employment at sheltered workshops (15). The idea of being clinically cured, an idea sometimes expressed as "work readiness," has proved to be unhelpful.

In the areas of housing and work, everyday solutions—with appropriate compensatory supports—for everyday problems has proved optimal. Does this principle extend to intimate relationships? Quite possibly. If the concept of readiness has proved unhelpful in relation to housing and employment, perhaps providing social skills training to someone who wants a relationship is equally unhelpful. The alternative, everyday solution is to support people's access to a pool of potential partners with whom they can learn relationship-building skills. Examples include accompanying individuals as they join a community-based social or sports club, work as a volunteer, use an Internet dating service, or attend a speed dating event.

These proactive approaches stretch the individual and the clinician in different ways. The individual may need support to take on these challenges, and it may be more helpful to frame them as learning opportunities rather than to expect initial success. Ongoing involvement and debriefing by clinicians or peers may well be required as the person learns to cope with the ups and downs of these experiences. Similarly, the clinician may need support through supervision to move beyond constraining clinical beliefs, such as the presumption that an individual must "get better" before doing normal things like dating.

Explanations of mental illness

If the principle of everyday solutions for everyday problems is accepted, other existing clinical approaches also become open for debate. For example, the search for meaning in life is perhaps universal. Mental illness can profoundly change perceptions of oneself, the world, and others. The experience of illness, whether a disorder of mental or of general medical health, involves identity challenge. Yet people with a mental illness are just as likely as any other citizen to seek meaning in their lives. If everyday solutions are to be the instinctive orientation of mental health workers, explanatory models of mental disorder need to be used judiciously. These models should explain the experience of mental illness but avoid imposing a specialist solution by creating a unidimensional, engulfing identity, such as "schizophrenic patient." Allowing space for diverse explanations across different dimensions, including clinical, functional, physical, social, and—most challenging of all—existential, becomes important (16).

Whether because of a legacy of Freudian views of religion as regressive and pathological or because clinicians are statistically more likely than the general population to hold atypical spiritual views, discussing spirituality is challenging for mental health workers (17). In fact, belief in a personal God is much less common among clinical or counseling psychologists (24%) than among the U.S. population (90%) (18). Providing opportunities to access spiritual experiences, for example, by reading Scripture, praying, attending places of worship, and using online religious resources; uplifting secular experiences, for example, through exposure to art, literature, poetry, dance, music, science, or nature; and

everyday spiritual methods for coping with adversity, such as efforts to establish personal boundaries, spiritual purification, and spiritual reframing are all potential areas of future clinical effort.

New ways of working

Overall, proponents of a recovery approach seek to reverse some priorities. People with mental illness don't need treatment—they need a life. Treatment may contribute to the process of striving for a life worth living, but it is a means, not an end.

There are, of course, caveats to this argument. Some of the suggestions made earlier are premature for people in the early stages of recovery, but resilience is developed by engagement rather than avoidance. Some people have mental illness–related problems for which there are no obvious everyday solutions, although those problems may not be the person's highest priority, and many mental illness–related problems dissipate when everyday problems are resolved. Finally, some people find that mental illness–related problems, such as hearing derogatory voices, memory problems, or paranoia, impede their efforts to find everyday solutions. Offering specialist treatments is often warranted and can be a building block in constructing an identity as a person in recovery. However, clinicians should retain an attitude of modesty consistent with the reality that many people find nonclinical ways to manage mental health problems.

The overarching principle of recovery is that the impoverished expectations, clinical preoccupations, and stigmatizing beliefs sometimes held by mental health workers should not preclude everyday ways of addressing common human problems. Treatments that are designed to support an individual's life goals may look different than treatments provided to serve a patient's best interests. Arguably, the strongest contribution of mental health services to recovery is to support everyday solutions to everyday problems.

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References

1. Goldman HH, Glied SA, Alegría M: Conclusion: mental health in the mainstream of public policy. American Journal of Psychiatry 166:1215–1216, 2009
2. No Health Without Mental Health: A Cross Government Mental Health Outcomes Strategy for People of all Ages. London, Department of Health, 2011
3. Rosenheck RA: Introduction to the special section: toward social inclusion. Psychiatric Services 63: 425–426, 2012
4. Warner R: Recovery from schizophrenia and the recovery model. Current Opinion in Psychiatry 22:374–380, 2009
5. Slade M: Personal Recovery and Mental Illness: A Guide for Mental Health Professionals. Cambridge, United Kingdom, Cambridge University Press, 2009
6. Leamy M, Bird V, Le Boutillier C, et al: A conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. British Journal of Psychiatry 199:445–452, 2011
7. Wright BA, Lopez SJ: Widening the diagnostic focus: a case for including human strengths and environmental resources; in Handbook of Positive Psychology. Edited by Snyder CR, Lopez SJ. New York, Oxford University Press, 2002
8. Slade M, Williams J, Bird V, et al: Recovery grows up. Journal of Mental Health 21:99–104, 2012
9. Silverstein SM, Bellack A: A scientific agenda for the concept of recovery as it applies to schizophrenia. Clinical Psychology Review 28:1108–1124, 2008
10. Le Boutillier C, Leamy M, Bird VJ, et al: What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. Psychiatric Services 62:1470–1476, 2011
11. Slade M: Mental illness and well-being: the central importance of positive psychology and recovery approaches. BMC Health Services Research 10:26, 2010
12. Dunn S: Creating Accepting Communities: Report of the MIND Inquiry Into Social Exclusion and Mental Health Problems. London, MIND, 1999
13. Robbins PC, Callahan L, Monahan J: Perceived coercion to treatment and housing satisfaction in housing-first and supportive housing programs. Psychiatric Services 60:1251–1253, 2009
14. Schinka JA, Casey RJ, Kasprow W, et al: Requiring sobriety at program entry: impact on outcomes in supported transitional housing for homeless veterans. Psychiatric Services 62:1325–1330, 2011
15. Pogoda TK, Cramer IE, Rosenheck RA, et al: Qualitative analysis of barriers to implementation of supported employment in the Department of Veterans Affairs. Psychiatric Services 62:1289–1295, 2011
16. Whitley R, Drake R: Recovery: a dimensional approach. Psychiatric Services 61: 1248–1250, 2010
17. Huguelet P, Mohr S, Betrisey C, et al: A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. Psychiatric Services 62:79–86, 2011
18. Pargament KI: Spiritually Integrated Psychotherapy. New York, Guilford, 2007