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Recovery discussion Topic – Boundaries

One of the differences between Peers and other clinical staff is the language that we use. Peer based learning and literature talks about ‘people’ and ‘individuals’. Over the last few years services have changed the use of the term patient to service user, following campaigns from service users. Much of the Department of Health literature still uses the term patients and some performance indicators for the Trust are specifically called ‘patient experience’ measures. The NHS continues to conduct the national NHS Patient survey. How much difference or influence does the use of these terms have on how we see the people we work with and is there a right or wrong phrase or word? Throughout this discussion topic the words people, individual or service user have been used as they were in the literature from which the learning was derived. As you go through think about how differently this makes you consider the issues outlined and whether one term or word brings out recovery better than another.

Peer Workers present a new approach to a therapeutic relationship and can be challenging to traditional models of the staff patient relationship. Peers are staff but they are employed explicitly because of their lived experience and, as such, are required to use this experience for the benefit of others. Other staff either with or without professional qualifications, have traditionally been told to withhold personal information for several reasons including:

- fear of compromising important boundaries which are required to ensure a therapeutic alliance which is not compromised by personal issues
- fear of leading the service user into vulnerable relationships
- fear of misleading people into seeing the staff member as a friend which may affect the outcome of any treatment
- or place the staff member at risk of being inappropriately exposed emotionally or personally.

Recovery Innovations Peer Training:
Peer workers give a very powerful message to people who don’t feel a lot of hope, self-worth, or belief in their ability to recover. They show that recovery is possible – a full life is possible. They show that people with psychiatric experiences can:

- Be strong and self-confident
- Take charge of their lives and their services
- Do for themselves, make their own choices, work, and contribute to the world
- Have lots of good experiences in life as their lives become less about ‘psychiatric stuff’ and more about ‘ordinary human stuff’

Most of the ways Peers show these things is just by being themselves and working as part of a multi-disciplinary team, undertaking generic duties as a Peer. Most of what they will be doing is listening and letting people talk about how they want to be supported, but sometimes they will talk about themselves, their experiences of Recovery and what is going on in their lives today.
Peers are taught that it is important to tell personal stories in a way that:

- Conveys a sense of the ‘whole picture’
- Inspires Hope

Peers are taught to avoid some pitfalls when sharing their story:

- Shifting the focus too much onto oneself
- Taking up too much time with their story
- Using the time to resolve their own pain or working through their challenges
- Comparing their story to the person’s
- Including specific details about trauma and other experiences that could be uncomfortable for the person.

The essence is to get a balance between being clear about similar experiences but of being able to provide to the person a sense of “If you can do it, I can do it too”

**Borg and Kristiansen (2004) explore Recovery-oriented professionals: helping relationships in mental health services.**

In this study, service users identified that becoming a recovery-oriented professional included a rethinking of what being a ‘professional’ means. They did not mean that the specialist knowledge and experience was worthless, rather that it involved courage on the part of the professional in learning how to apply their skills and expertise in a more collaborative way, sharing power and acknowledging the wisdom and insight of people with lived experience.

Recovery is seen as an active process on the part of the individual and is not something professionals do for or to the passive individual. The job of the professional is to discover, support and engage the individual’s capacity to recover.

The study suggests that understanding relationships and the context of those relationships is necessary for the professional to create a partnership which requires a genuine interest in, and understanding of, the person’s experience and an ability to deal with the person’s pain, worry, anxiety and perhaps ‘challenging behaviour’.

In the study, professionals were found to be helping and supportive when they gave priority to establishing a positive relationship and where optimism and focus on the individual’s inner resources were emphasised. The stories told in the study represented both encounters with collaboration and genuine care but also encounters of hopelessness and humiliation.

Some services and staff were still seemingly influenced by Kraeplin’s long established legacy of schizophrenia as a chronic disease with poor outcomes (Davidson 2003) and this belief is often transmitted to the help-seeking individual.

This long standing belief was found to be alarming considering that research has long confirmed that recovery from severe mental illness is possible and realistic, with many good reasons for hope (Strauss 1989, 1992, Harding and Zahinster 1994, Harrison et al 2001, Davidson 2003).

The findings pose the question “When professionals show a little bit of themselves, might it also be easier for the service user to do the same?” This study raises the question related to the expectations of the professionals to be competent in so-called evidence based practice whilst also striving to hold a service-user perspective.
100 Ways to support Recovery (Mike Slade and Rethink 2009) identifies an important aspect of professional relationships as mutuality – the view that we have all recovered from something and that it is helpful to emphasise that we all have this in common. That the recovery worker is prepared to work alongside and therefore be more exposed to the person, and sees their job as providing choices rather than fixing the problem.

The recovery worker may also be challenged, influenced and changed by the service user. The paper also recognises there are times when services need to take responsibility for an individual and that similarly there are times when a person wants a professional view – about diagnosis, prognosis and treatments. A style of communicating that is commonly identified in recovery orientated services is the coaching style. The features of this are:

1. The person is invited to take personal responsibility

2. The focus is on how the person can live with mental illness, and differs from the traditional focus on treating the mental illness.

3. The role of the coach is to help the person become active, rather than to fix the problem. This leads to focus on strengths and existing supportive relationships, rather than on deficits.

4. Effort in the coaching relationship is directed towards the goals of the coachee, not the coach. The skills of the coach are a resource to be offered.

5. Both participants must make an active contribution for the relationship to work.

Professional expertise remains central, although it is deployed to support self-management. This shift towards partnership relationships requires the use of professional expertise in a different way, where the processes of assessment, goal planning and treatment all support recovery.

Action points:
1. Attach at least as much importance to the wishes and preferences of the service user as to professional views.

2. Wherever possible be led by the priorities of the service user

3. Be open to learning from and being changed by the service user

4. Wherever possible, use coaching skills

5. Give and receive supervision which considers the relationship as well as technical intervention competencies.

CPFT
Up to 30% of CPFT workforce, in any one year, is likely to experience some mental health problems. Approximately 1 in 4 of us will experience mental health problems at some point in our life. So it stands to reason that although only Peers have been employed explicitly because of their lived experience many staff employed in other roles may also have lived experience of mental ill health.
So how able do these people feel to be open about this lived experience with their
team/peers and further, how comfortable would they feel about sharing this lived
experience with the people CPFT delivers services to?

- If these other staff started sharing lived experiences what would their team’s
  reaction be?

- What might the pitfalls be - are these real or myths developed by professionals
  over decades when working in historical settings?

- Which are the real issues that we need to be mindful of?

**Questions for discussion:**

1. What is different for Peers in that they can tell their personal story without
   compromising the intentional relationship boundaries?

2. Could your personal story of recovery provide an essential component of your
   therapeutic relationship with the people you see? Could you provide a hope
   inspiring role model by doing so?

3. What benefit would a staff member achieve by telling their own story of
   recovery?

4. What are the barriers to using your lived experience in your work? How might
   these be overcome?

5. Being more open about ourselves and our own experiences may help in the
   development of hope inspiring relationships but is there a cost or risk to this?
   What might these risks be and how might these be overcome?

6. Not everyone has lived experience. How else can you develop a collaborative
   relationship with the people you work with that helps you to work together
   towards recovery?

7. Are there aspects of your beliefs which are influenced by the traditional views of
   serious mental illness and recovery?
   - How is this influencing your practice and your views of what service users
     can achieve?
   - How are these beliefs affecting the work you do?
   - What could you do to shift your beliefs and attitude?
References


- Department of Health (2007), Capabilities for inclusive Practice


- Slade M. and Rethink (2009), 100 Ways to support Recovery – a guide for mental health professionals
