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## **Everyday solutions for everyday problems**

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## **Abstract**

People who experience mental illness can be viewed as either fundamentally different from, or fundamentally like, everyone else in society. Recovery-oriented mental health systems focus on commonality. In practice, this involves an orientation towards supporting everyday solutions for everyday problems, rather than on providing specialist treatments for mental illness-related problems. This change is illustrated 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 are a means not an end. Mental health systems which offer treatments in support of the individual's life goals are very different to those which treat patients in their best interests. The strongest contribution of mental health services to recovery is to support everyday solutions to everyday problems.

## **Mainstream and exceptionalist public policy**

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 about the best balance between mainstream public policy and exceptionalist mental health-specific policy in the USA (1). Summarising a series of articles arguing for a shift towards mainstream policy, the authors identify two conclusions. First, understanding the contribution of mental health research to mainstream public policy is in the interests of all. Second, this shift changes the metrics for evaluating success, away from traditional clinical imperatives such as symptomatology and relapse rates, and towards valued social roles such as residential stability and labor force participation.

This shift towards emphasising commonality over difference is mirrored in the UK. Current mental health policy identifies six outcomes to improve mental health for the population: better physical health, supporting recovery, improving experience of services, reducing avoidable harm, decreasing stigma, and improving population well-being (2). This changes the balance from previous policy arrangements, away from special policy for dealing with mental health problems and towards integration of mental health policy into mainstream social policy – reflected in its title “*No health without mental health*”.

Although less explored, the same question arises at the level of the individual. Two classes of problem and two classes of solution can be distinguished.

People using mental health services often have both everyday problems (of the sort experienced by others in their community) and more specifically mental illness-related problems (e.g. symptoms, cognitive difficulties). Service provision needs to balance work across these two classes of problems. Similarly, everyday solutions as used by others in their community can be contrasted with specialist solutions (*i.e.* treatments). Again, the challenge for services is achieving the right balance. The traditional approach has perhaps been to prioritise specialist solutions for mental illness-related problems - treat the person so they can subsequently get on with their life. However, in a recovery-oriented mental health system, the balance changes towards supporting everyday solutions for everyday problems.

### **An illness or a person?**

A recovery orientation is central to mental health policy throughout the English-speaking world. The scientific evidence underpinning this re-orientation has been collated (3, 4). What are the practical implications?

Development and consolidation of identity is central to recovery (5). The construct of identity has emerged from three academic disciplines (4). A sociological understanding of identity emphasises **commonality**, the ways in which we are like other people. A psychological understanding emphasises **difference**, the ways in which we are unlike others. A philosophical understanding emphasises **permanence**, persistence of identity over time and space. Mental illness creates a sense of difference - being alone or helpless or tainted or hopeless - in the individual. Clinical processes which

further emphasise difference, such as assessment processes focussed on intrapsychic deficits, can inadvertently contribute to the development and maintenance of a stigmatised identity as a mental patient. Indeed, the focus on intrapsychic deficits to the exclusion of intrapsychic strengths (e.g. artistic skills) and environmental deficits (e.g. poverty) and strengths (e.g. cultural resilience) is a long-standing criticism of the mental health system (6). Supporting recovery involves amplifying commonality and permanence rather than difference and transience. This can be summarised as “*Recovery begins when you find someone or something to connect with*”. The job of the system is to support this connection with self (permanence) and others (commonality).

The central shift involved in a recovery-oriented system is therefore from seeing a patient - someone who is fundamentally different and so needs treatment before they can get on with their life - to seeing a person who is fundamentally similar to people without mental illness in their efforts to “*live the most fulfilling lives that they can live*” (7). What does this mean for clinicians?

### **Supporting recovery**

International best practice in supporting recovery identifies four domains of action: Supporting personally defined recovery (what you do), Working relationship (how you do it), Organizational commitment, and Promoting citizenship (8). This last domain has been the least investigated, yet plausibly is the most influential. Improving social inclusion and community integration

may involve a much wider role for clinicians than providing treatments (9), with more attention paid to supporting the person to make connections in their life, and to the creation of inclusive communities: “*Social inclusion must come down to somewhere to live, something to do, someone to love. It’s as simple - and as complicated - as that*” (10). How can clinicians support people to meet housing, employment and relationship goals?

For housing, the requirement for mental health or substance abuse treatment as a precondition for obtaining housing differentiates two approaches. Emerging evidence suggests the everyday solution (no precondition – ‘housing first’ model) leads to greater consumer satisfaction than the specialist solution (‘supported housing’ model) (11). The assumption that being a good tenant should be a requirement for obtaining tenancy has proved unhelpful, e.g. the impact of sobriety at program entry on outcome is minimal (12)

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 sheltered workshops providing non-competitive employment (13). This points to the benefits of the principle of everyday solutions for everyday problems, with compensatory supports provided as needed in order to access those everyday solutions. The idea of being clinically fixed – or ‘work-readiness’ as it is sometimes expressed – has proven to be unhelpful.

Does this principle extend to intimate relationships? Quite possibly. If the concept of 'readiness' has proved unhelpful in relation to housing and employment, then perhaps it is equally unhelpful when social skills training is provided for someone who wants a relationship. The alternative, everyday solution is to support the person to have access to a pool of potential partners with whom they can learn relationship-building skills. Examples include going with the person to join a community-based social or sports club, do voluntary work, use an internet dating service, or go on a speed dating event. These proactive approaches are stretching, in different ways, for the individual and the clinician. The individual may need support to take on these challenges, and it may be more helpful to frame them as learning opportunities rather than expecting initial success. Ongoing involvement and debriefing may well be required as the person learns to cope with the ups-and-downs these experiences will involve. Similarly, the clinician may need support through supervision to move beyond constraining clinical beliefs, such as the importance of being 'better' before doing normal things like dating.

If the principle of everyday solutions for everyday problems is accepted, then 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 self, world and others. The experience of mental ill-health therefore involves identity challenge like many physical disorders. Yet people with mental illness are just as likely to be seeking meaning in their life as any other citizen. If everyday solutions are to be the instinctive orientation of mental health workers, then explanatory models of



mental disorder need to be used judiciously – to provide an account of the experience of mental illness, but also to avoid imposing a specialist solution by creating a uni-dimensional engulfing identity, such as a schizophrenic patient. Allowing space for diverse explanations across different dimensions becomes important, including clinical, functional, physical, social and – most challengingly – existential (14). Whether due to a legacy of Freudian views of religion as regressive and pathological, or because professionals have (statistically) abnormal spiritual views – 90% of the US population believe in a personal God, compared with 24% of clinical or counselling psychologists (15) - evidence indicates that discussing spirituality is challenging for workers (16). Providing opportunities to access spiritual experiences (e.g. reading scripture, prayer, attending places of worship, on-line religious resources), uplifting secular experiences (e.g. through exposure to art, literature, poetry, dance, music, science or nature) and everyday spiritual methods for coping with adversity (e.g. marking boundaries, spiritual purification, spiritual reframing) are all potential areas of future clinical effort.

### **New ways of working**

Overall, the argument is 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 is a means not an end.

There are of course caveats. Some of the above suggestions will be premature for people in the early stages of recovery, but resilience is developed by engagement rather than avoidance in life. Some people have

mental illness-related problems for which there are no obvious everyday solutions, although these 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 derogatory voices, memory problems or paranoia impede their efforts to find everyday solutions. Offering specialist treatments is often warranted and can be a helpful building block in constructing an identity as a person in recovery, although clinicians need to retain the modesty consistent with the reality that many people find non-clinical ways of self-managing their mental health problems.

But the overarching principle is to ensure that the impoverished expectations, clinical preoccupations and stigmatising beliefs sometimes held by mental health workers do not preclude everyday ways of addressing common (in both senses) human problems. Mental health systems which offer treatments in support of the individual's life goals may look different to those which treat patients in their best interests. Arguably, the strongest contribution of mental health services to recovery is to support everyday solutions to everyday problems.

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