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through a 'person-centred' approach

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What is This?
Reclaiming the best of the biopsychosocial model of mental health care and ‘recovery’ for older people through a ‘person-centred’ approach

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Abstract

Aim: The ‘biopsychosocial’, ‘person-centred care’ (PCC) and ‘recovery’ models of care can be seen as distinct and competing paradigms. This paper proposes an integration of these valuable perspectives and suggestions for effective implementation in health services for the elderly.

Method: An overview of PCC and recovery models, and their application for older people with mental health problems, is provided. Their overlap and contrast with the familiar ‘biopsychosocial’ model of mental health care is considered, together with obstacles to implementation.

Results: Utilisation of PCC and recovery concepts allow clinicians to avoid narrow application of the biopsychosocial approach and encourages clinicians to focus on the person’s right to autonomy, their values and life goals.

Conclusions: Service reform and development is required to embed these concepts into core clinical processes so as to improve outcomes and the quality of life for older people with mental health problems.

Keywords: biopsychosocial, older persons mental health, person-centred care, recovery

The recent promotion of ‘recovery’ within mental health and ‘person-centred care’ (PCC) within aged care services can potentially be seen as competing paradigms with each other and the familiar biopsychosocial model of mental health care. This paper demonstrates how key concepts from these models can be integrated and utilised to optimise outcomes in older people with mental health problems.

Services that provide mental health care to older people are diverse in settings, models and organisation. Treatment objectives includes restoration of health, improving quality of life, minimising disability, preserving autonomy and addressing supporters’ needs. This is frequently provided in the community (including residential aged care facilities), but also within inpatient settings when community care is unsafe or ineffective. These services complement the mental health care provided by general practitioners and other primary care providers. Irrespective of the setting or provider, core clinical processes include a comprehensive assessment, care planning, provision of interventions, monitoring of progress, liaison with other services and follow-up care, provided by a multidisciplinary team who utilise a biopsychosocial approach. The biopsychosocial model, first proposed by Engel to address the diagnostic and treatment approaches to

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psychosomatic illness, provides a framework acknowledging the relative contributions of biology, psychology and social issues to the health presentations as well as treatment responses, level of psychological, physical and social functioning. Critics claim that the model can be overly eclectic, resulting in loss of scientific rigour and testability of hypotheses and allowing practitioners’ to choose their ‘metier’ without taking into account the other pillars of the framework. Others claim that the model can be narrowly applied, focusing on deficits and illness, to the exclusion of ‘personhood’ and respect for autonomy. However, supporters of Engels claim that the model was always intended to be practised within a value system that was empathic and respectful of autonomy.

PCC and recovery evolved as a response to adverse institutional experiences related to limited attention paid to psychosocial needs and the individual’s right to autonomy.

**Person-centred care**

It has been proposed that the term PCC is ambiguous, overused, has differing definitions and therefore, communicates very little, but it is important to recognise that it means much more than individualised care. Having origins in Rogerian psychotherapy, it is now commonly used in dementia care. This followed the work of Kitwood, who brought together ideas and ways of working with people with dementia that emphasise communication, relationships and exploration of their lived experiences.

PCC is described as holistic and humanistic and aims to achieve the most favourable outcome for the patient as well as their carers and family. It encompasses a social model which emphasises wellbeing, social inclusion, self-management and hope. The hallmark of PCC is promotion of personhood, despite deteriorating cognitive function, where the rights and respect for the person as an individual are paramount.

The process of PCC includes ‘working with patients’ beliefs and values, having sympathetic presence, sharing decision-making and providing for physical needs’, achieved by professionals engaging in a therapeutic relationship with the patient that has been ‘built on trust, understanding and a sharing of collective knowledge’ formulated through the exploration of the person’s life history and lived experiences. Planning care should be a two-way process that is co-owned by the person at the centre of care.

**Recovery**

Recovery has become the dominant concept informing mental health service delivery in Australia and elsewhere (beginning with the US and New Zealand from the 1990s). There are a number of competing definitions, but core elements include:

- ‘Recovery’, from the effects of mental illness including stigma and lost opportunities for growth;
- Acknowledging interdependency, resort to informal sources of help while minimizing undue reliance on health professionals;
- Maintaining or restoring hope;
- Fostering one’s own coping strategies and self-agency;
- The dignity of risk-taking and the right to fail;
- Maximizing use of client-driven definitions of recovery from illness;
- A move away from deficit models of illness;
- A greater emphasis on psychosocial aspects of wellness (with overlapping components of ‘social inclusion’);
- An emphasis on the importance of hope and a search for individual meaning in life, which may include commitment to work, social engagement and/or spirituality.

All definitions of the recovery model envisage change in the power balance between the clinician and the individual, which sits in opposition to negative or narrow images of psychiatry as domineering, depersonalising, institutional or purely ‘medical’.

Some authors distinguish between recovery as a model that informs clinical process and outcomes (the person in healthcare experience, individualised goal setting) and recovery as a ‘journey’ toward a worthwhile life irrespective of loss and disability. The Australia National Mental Health Policy 2008 emphasises the latter perspective.

**Recovery in older people**

There are barriers to implementation of ‘recovery-based’ care into mental health services for older people:

1. Most of the recovery literature relates to mental illness experiences in early or middle adulthood;
2. Dementia is often not included within the concept of ‘mental illness’ by ‘mental health’ consumers, carers or agencies, whilst many services have a significant caseload of people for whom dementia is the primary diagnosis;
3. ‘Recovery’ may seem an inappropriate term used in the care of those people for which the prognosis is irreversible functional loss or inevitable decline (e.g. those with dementia), and misinterpretation may give consumers or family false hope;
4. Health and welfare sector partners for older people are familiar with PCC but unfamiliar with the recovery model.

Other issues not usually considered in the recovery literature include the limited capacity of some older people to make or contribute to health care decisions and the consequent need to involve family, carers and/or...
formal substitute decision-makers. However, many underlying concepts of recovery are relevant to older people, and can be adapted to engender realistic hope and fulfilment, even in people with dementia, by optimising their potential.7

Implementation of PCC and recovery in mental health services for older people

There is a growing body of literature providing evidence that utilisation of a PCC and recovery framework used in various settings results in better outcomes for patients, family and carers. This has prompted the widespread adoption of these principles in policy and practice 2,7,17. However, the implementation of these principles is frequently problematic.

One way to meet this challenge is to assist clinicians to develop a shared paradigm based on both PCC and recovery models, which is consistent with the policy frameworks of both aged care and mental health, building on the strengths of the biopsychosocial model of mental health care for older people.

PCC reminds mental health clinicians that a core responsibility is to understand the person, their likes and dislikes, key influences in their life and their life goals, and use this knowledge to guide every intervention and interaction with patients and their supporters. Recovery promotes that ‘treatment’ is a small, yet important part of the journey through life with mental illness, and that quality of life is enhanced if the individual has control of their life. This means that dependency is less likely to be fostered and individual strengths and abilities difficult to ignore.

Recovery focuses upon the empowerment of the individual with mental illness, maximising control of their life and choice of assistance, while PCC focuses on individuals who require assistance from others and requires carers and clinicians to act and communicate in a way which demonstrates support and respect for the patient’s ‘personhood’.

All three concepts aim to improve the quality of life for the individual patient and those close to them. All acknowledge the importance of understanding the individual patient within the context of their mental illness or distress, physical health, life history and social environment. While there are important variations and differences noted in the concepts, the best features from all can be incorporated harmoniously to provide optimal patient and carer outcomes.

Service processes and reforms required to optimise utilisation of PCC and recovery in routine clinical care

The long-agreed core processes of older persons’ mental health care both support and reflect the key principles of PCC and recovery models of care. In best practice settings, the patient’s social and personal history is obtained in a respectful and interested fashion that builds rapport and fosters a sense of self-efficacy and pride in personal achievements. If the patient lacks some aspects of capacity or has a substitute decision-maker, the appropriate guardian or family members are included in the discussions. This is undertaken in a way that builds the relationship, while optimising the patient’s sense of autonomy and personal dignity. Biological, psychological and social aetiological factors, risks and treatment options are considered and discussed with the patient along with substitute decision-makers and family. These are encouraged to take responsibility for their life, treatments, wellness and recovery. A collaborative approach to care planning and recovery is negotiated with the aim of optimising wellbeing and quality of life for the patient and his or her carers. Such care is effective and satisfying to provide.

However, the time required for comprehensive assessments, family meetings and collaborative care planning, can be rationed when staff resources are limited. The trend to increased job-sharing or part-time staff may exacerbate these challenges. This can also result in clinicians being poorly trained, mentored and supervised with respect to PCC and recovery models. It is important to note that factors which affect the control, frequency of contact, and quality of communication can adversely affect the client–clinician relationship,18 and patient outcomes. Even the best consultant or team leader cannot understand the core nature of a person and their goals without sufficient time, excellent communication from other team members, and respect for their abilities. Consequently, the negotiation of goals and treatment options can be replaced with an explanation of the best ‘treatment’ based on the clinician’s judgement. Implementation of care can then require adherence to treatment rather than empowerment of the patient and shared decision-making. An unnecessarily paternalistic approach emerges.

Services must not assume that clinicians understand and deliver person-centred or recovery-focused care, but develop clinical and organisational processes which:

- support a shared understanding by the patient, carer and treating team members of key aspects of the ‘person’;
- develop collaborative care partnerships;
- strive for the ‘recovery’ desired by the patient and their carers;
- encourage monitoring and measurement of progress towards agreed treatment goals.

Recovery and PCC also requires health services to be prepared to accept risks associated with maintaining autonomy.

These are significant changes for an organisation and will be challenging in different ways to different individuals. This will require commitment to education,
training, mentoring and also redesign of services and care delivery. However, if recognised and worked through in a supportive manner, sustained change can occur.\textsuperscript{19,20,21}

Conclusions

This paper reflects a clinical perspective of the evolution and integration of three key concepts in mental health and their application to the care for older people. The biopsychosocial model of mental health care emphasises the importance of holistic approaches to health care. Core principles of mental health and aged care can be integrated through utilisation of a PCC framework, allowing recovery concepts to be more meaningful for older people and the clinicians working with them. Applying these in daily practice requires translation of concepts to changes in clinicians’ day-to-day actions, and does not happen without significant effort. However, it is an effort that can bring rewards for patient, carer and clinician.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of this paper.

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