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Original article

PERCEIVED SUPPORT FOR PERSONAL RECOVERY AND RELATIONS IN MENTAL HEALTH SERVICES AMONG SERVICE USERS WITH SEVERE MENTAL ILLNESS: CROSS-SECTIONAL ANALYSIS OF BASELINE DATA BEFORE CONSTITUTION OF MENTAL HEALTH COMMUNITY-BASED TEAM

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Abstract

Perceived support for personal recovery in mental health services and good relationships with the mental health team are an important indicator for quality of care among service users with severe mental illness (SMI). This study investigated the perceived support for personal recovery and relationships with the mental health team in mental health services among service users with SMI in North Macedonia.

A total of 180 service users diagnosed with psychosis were assessed using the INSPIRE questionnaire.

A large majority (statistics is included) of participants reported moderate levels of perceived support for personal recovery in mental health services and moderate to high levels of satisfaction from the relations with the mental health team.

Keywords: severe mental illness, mental health services, INSPIRE questionnaire

Introduction

The perceived support by the mental health team of service users is considered an important indicator of the quality of care and affects personal recovery in users with SMI[1,2]. Satisfied service users with SMI are more attached to members of the mental health team, more receptive to treatment, and benefit more from care[1], while those who are less satisfied have poorer treatment outcomes[3]. Satisfaction with services, relationships with the mental health team, and the perceived support can affect treatment success in users with SMI[1,3,4].

The perceived support by the mental health team is an important indicator of the quality of care in SMI service users in terms of their personal recovery[5-9]. Supporting and focusing on personal recovery is a key goal in mental health services in many countries[10-13] and has a significant impact on health policy[14]; it promotes a client-oriented and community-oriented service orientation through community mental health teams[15-18] in order to improve the quality of life of people with SMI[15-18].

There are still no mental health teams in North Macedonia and there are still no studies assessing the differences between SMI users in terms of gender, education, marital status, monthly income and their satisfaction with the support they receive and satisfaction with the relations with the mental health team in the existing mental health services.

The aim of this study was to examine the perceived level of support for personal recovery and relations with the mental health team among service users with SMI across North Macedonia before establishing community mental health care team and to compare the differences according to gender, education, marital status and income.

Method

This report is based on cross-sectional data from the North Macedonian research site in the RECOVER-E project-(Clinical Trials NCT03892473). Specifically, baseline data of a hybrid effectiveness-implementation trial was analyzed, related to perceived support. Data was thus collected before service users were randomized into treatment (CMHT) and control (CAU) conditions. All participants were informed about the study and provided written informed consent before screening for inclusion.

The study was approved by the Ethics Committee for Research on Human Subjects at the Faculty of Medicine, Ss. Cyril and Methodius University in Skopje, No. 03-2237/13 dated 21.05.2018, and followed the principles of the Declaration of Helsinki.

Setting and sample

A total of 180 patients at the University Clinic for Psychiatry, Skopje, North Macedonia were recruited among current and new users of a mental health service (ambulance or hospital treatment with a psychiatrist and a psychologist). Following their initial evaluation and enrolment in the community-based service delivery model for recovery-oriented care, they were referred to the study by the clinicians. Inclusion criteria were:

1) Age 18 to 65 years;
2) Meeting criteria for bipolar disorder, severe depression, or schizophrenia (SMI) according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or International Statistical Classification of Diseases and Related Health Problems (ICD-10). The person should require care and treatment and not be in symptomatic remission;
3) Having severe limitations in social and community functioning and not in functional remission;
4) These problems are not transient in nature; the problems are systematic and long-term, and potentially chronic, intermitted, and/or recurrent;
5) Coordinated care provided by care networks or multidisciplinary teams is needed to deliver treatment.

Participants were excluded from the study if they:

1) Did not provide consent to their data being collected;
2) Were in an acute crisis at the time of recruitment into the study;
3) If there was a presence of a terminal somatic comorbidity that would make long-term follow-up difficult;
4) Were incarcerated.

Measure

All respondents answered questions regarding their gender (male, female, I do not want to answer), level of education (primary, secondary, faculty and more), marital status (have partner, do not have, do not want to say) and have monthly income (yes, no, do not want to say).

Perceived support for personal recovery and relations (agreement on working towards the same goals and being respectful to each other) with the mental health team were examined using

the 20-item support subscale from the *INSPIRE* measure of staff support of personal recovery (INSPIREs) and the 7-item relations subscale from the INSPIRE relations (INSPIREr)[19]. First, for each subscale item, service users rated what was important for their recovery (e.g., "An important part of my recovery is... feeling hopeful about my future, (Yes/No). If yes was chosen, the service user rated the support they received from their health service provider in ambulance or hospital for this item ("I feel supported by my worker with this") on a five-point Likert scale from 0 (Not at all) to 4 (Very much). A total support score is calculated for each participant as described in the INSPIRE scoring instruction guide[20] and ranges from 0 (low support) to 100 (high support) in perceived support and 0 to 25 in satisfaction with relations with the mental health team ("I feel supported by my worker").

The 20-item support subscale has acceptable psychometric properties, including convergent validity (0.60) and adequate sensitivity to change. Exploratory factor analysis (variance 71.4-85.1%, Kaiser-Meyer-Olkin 0.65-0.78) and internal consistency (range 0.82-0.85) indicate each recovery domain is adequately assessed. The 7-item relations sub-scale has convergent validity 0.69, test-retest reliability 0.75, internal consistency 0.89, a one-factor solution (variance 70.5%, KMO 0.84) and adequate sensitivity to change[19,20].

Procedure

Clinicians at the participating mental health units recruited eligible service users who were in contact with the clinic during the study period, and newly referred service users assessed to have SMI. The questionnaires were administered to service users by a psychiatrist and a psychologist. Service users were either provided with a place to sit in the clinic to complete the questionnaires, or took them home. When finished, the questionnaire was sealed in an envelope, and returned to the clinic. The recruitment period lasted from June 2018 until December 2018, and only participants who gave written informed consent were included.

Analysis

Data were analyzed using the SPSS-26 version, for Windows, PC. The descriptive analyses were conducted on the basis of means and standard deviations. ANOVA tests were used to determine whether there were differences in INSPIRE scores between different sociodemographic groups of patients.

Results

Of the 180 patients who were examined, 178 had valid complete data. In total, they rated the received support as intermediate. Satisfaction with the relationship with the mental health team was at a medium-high level (Table 1).

Table 1. INSPIRE scores

	M	SD
INSPIREs	60.20	19.67
INSPIREr	28.51	4.42
INSPIRE	88.92	21.33

Male respondents had similar scores on all subscales, but without a statistically significant difference (Table 2).

Table 2. INSPIRE scores by gender

	M female	SD	M male	SD	F	Sig.
INSPIREs	59.93	19.98	60.63	19.47	.053	.818
INSPIREr	28.52	4.63	28.42	4.13	.024	.876
INSPIRE	88.63	21.66	89.30	21.14	.041	.839

Table 3. INSPIRE scores by education

	M primary	SD	M secondary	SD	M faculty	SD	F	Sig.
INSPIREs	59.19	18.87	53.00	15.51	61.32	20.50	.700	.624
INSPIREr	27.60	4.27	27.00	4.85	29.14	4.41	1.205	.309
INSPIREr	87.19	20.31	80.00	17.68	90.56	22.22	.817	.539

Respondents with primary education showed the lowest level of support experience in the process of their recovery and satisfaction with staff relations, while those with higher education showed the highest level of experience support as well as satisfaction with staff relations.

Regarding education, respondents showed no statistical differences in terms of perceived support for personal recovery in mental health services and relations with the mental health team (Table 3).

Table 4. INSPIRE scores by marital status

Marital status	M no partner	SD	M have partner	SD	M does not say	SD	F	Sig.
INSPIREs	63.51	17.68	53.39	22.54	56.58	22.11	4.086	.019
INSPIREr	28.90	4.07	28.00	4.28	26.83	5.93	2.371	.097
INSPIRE	92.19	19.80	82.40	22.49	83.41	24.90	3.672	.028

Statistically significant differences were observed for perceived support as well as the global satisfaction of the respondents comparing the groups by their marital status. Respondents who do not have a partner showed a higher level of experience of support than those who do not have a partner and those who do not declare their status. Those who have a partner were in the range from low-intermediate to intermediate level of support experience, while those who do not have a partner had a supportive experience in terms of their treatment from intermediate to intermediate-high level. Marital status groups did not differ in how they assessed staff relations (Table 4).

Table 5. INSPIRE scores by income

Income	M have income	SD	M das not have income	SD	F	Sig.
INSPIREs	62.40	19.34	58.91	19.82	1.316	.253
INSPIREr	28.90	4.01	28.26	4.65	.859	.355
INSPIRE	91.31	21.60	87.46	21.13	1.341	.249

Respondents who have a certain income showed a slightly higher experience of support in terms of their recovery than those who have no income, while satisfaction with staff relations was at the same level. There were no statistically significant differences in terms of income of respondents (Table 5).

Discussion

The aim of this study was to examine the perceived level of support for personal recovery and relations with the mental health team among service users with SMI across North Macedonia before establishing community mental health care team and to compare the differences according to gender, income, marital status and education.

Most of the service users (89%) rated their support as intermediate to high. Overall, our results showed higher satisfaction rates than those reported in similar international studies. Compared to a Dutch study[6], covering 654 service users with psychosis, our study showed more positive results. However, despite similar samples and recruiting methods, their sample included more users experiencing their first episode of psychosis, and hence their sample was younger, which is often associated with less satisfaction. Compared to the studies from Israel[8], Kuwait[9] and the multi-site European study[7], our satisfaction scores seemed markedly higher, which may be due to the fact that in North Macedonia the members of the mental health team establish closer relations with the service users and become more emotionally involved in their treatment process.

Given that it is important for users to be more emotionally involved by the mental health team, and in the outpatient clinic appointments are limited in time, it is very important to form community mental health teams that can be more committed to SMI users, tailored to individual needs. This indicates that it is important to support service users with SMI in their personal recovery to represent individual – person focused program, which calls for implementation of assertive recovery-oriented practices[20-23].

These may help to understand the subjective experiences that are key in treating people with mental disorders and improve patient-clinician communication. Moreover, better communication is related to decrease in the paternalistic view of care as well as increase in interactive approaches with patients and patient decision-making, all of which lead to increased patient satisfaction[24-26]. In fact, patient satisfaction predicts future behaviors including adherence with treatment, intent to return for care in the crisis period[27-29].

This is especially important since patient centeredness and personal recovery are the growing policy focus for mental health services. Studies should also include clinical outcomes, to better explain how these constructs interact. A mixed-methods study involving qualitative exploration of the experience of recovery support could also help develop an understanding of this process and inform the future development of more targeted interventions by mental health community base teams with effectively reducing the use of inpatient care[30-32]:

- based in a community setting,
- operating an extended hours service,
- the team manager having clinical as well as managerial responsibilities,
- the team having full clinical responsibility for their patients,
- daily team meetings in order to organize work priorities for the day,
- adopting a ‘shared case load’ whereby all staff work flexibly with the team’s patients, rather than using an individual case management approach, and
- offering a ‘time unlimited’ service that avoids discharging patients because of disengagement.

Conclusion

Psycho-social rehabilitation of people with severe mental disorders is the core of the community mental health system, which is a flexible system and which should be organized

according to the patient's needs. Recovery model should follow patients' characteristic and adapt to the characteristics of the society and local community as well. Organization of the services should offer and implement treatment planning which is focused around individual patients' personal strengths and needs, thus improving their effort for reintegration in the community.

Conflict of interest statement. None declared.

References

1. Priebe S, Miglietta E. Assessment and determinants of patient satisfaction with mental health care. *World Psychiatry* 2019; 18(1): 30-31. doi: 10.1002/wps.20586.
2. Shipley K, Hilborn B, Hansell A, Tyrer J, Tyrer P. Patient satisfaction: a valid index of quality of care in a psychiatric service. *Acta Psychiatr Scand* 2000; 101(4): 330-333. PMID: 10782555.
3. Smith D, Roche E, O'Loughlin K, Brennan D, Madigan K, Lyne J, *et al*. Satisfaction with services following voluntary and involuntary admission. *J Ment Health* 2014; 23(1): 38-45. doi: 10.3109/09638237.2013.841864.
4. Woodward S, Berry K, Bucci S. A systematic review of factors associated with service user satisfaction with psychiatric inpatient services. *J Psychiatr Res*. 2017; 92: 81-93. doi: 10.1016/j.jpsychires.2017.03.020.
5. Reininghaus U, Priebe S. Measuring patient-reported outcomes in psychosis: conceptual and methodological review. *Br J Psychiatry* 2012; 201(4): 262-267. doi: 10.1192/bjp.bp.111.107615.
6. Vermeulen J, Schirmbeck N, van Tricht M, de Haan L, investigators OoP. Satisfaction of psychotic patients with care and its value to predict outcomes. *Eur Psychiatry* 2018; 47: 60-66. doi: 10.1016/j.eurpsy.2017.10.003.
7. Ruggeri M, Lasalvia A, Bisoffi G, Thornicroft G, Vazquez-Barquero JL, Becker T, *et al*. Satisfaction with mental health services among people with schizophrenia in five European sites: results from the EPSILON Study. *Schizophr Bull* 2003; 29 (2): 229-45. DOI: 10.1093/oxfordjournals.schbul.a007000.
8. Ratner Y, Zendjidjian XY, Mendyk N, Timinsky I, Ritsner MS. Patients' satisfaction with hospital health care: Identifying indicators for people with severe mental disorder. *Psychiatry Res* 2018; 270: 503-509. doi: 10.1016/j.psychres.2018.10.027.
9. Zahid MA, Ohaeri JU, Al-Zayed AA. Factors associated with hospital service satisfaction in a sample of Arab subjects with schizophrenia. *BMC Health Serv Res* 2010; 10: 294. https://doi.org/10.1186/1472-6963-10-294.
10. Davidson L, Rakfeldt J, Strauss J. The roots of the recovery movement in psychiatry: Lessons learned: John Wiley & Sons; 2011. ISBN: 978-0-470-77763-3.
11. Slade M, Hayward M. Recovery, psychosis and psychiatry: research is better than rhetoric. *Acta Psychiatr Scand* 2007; 116(2): 81-83. doi: 10.1111/j.1600-0447. 2007.01047.x.
12. Slade M, Amering M, Oades L. Recovery: an international perspective. *Epidemiology and Psychiatric Sciences* 2008; 17(2): 128-137. DOI: 10.1017/s1121189x00002827.
13. Slade M, Leamy M, Bacon F, Janosik M, Le Boutillier C, Williams J, *et al*. International differences in understanding recovery: systematic review. *Epidemiol Psychiatr Sci* 2012; 21(4): 353-364. doi: 10.1017/S2045796012000133.
14. World Health Organization. Mental health action plan 2013-2020. Geneva 2013. ISBN: 9789241506021. https://www.who.int/publications/i/item/9789241506021.

15. Болнички морбидитет од ментални заболувања во Република Македонија, 1998-2012. Институт за јавно здравје на Република Македонија, Анкета спроведена во соработка со ЦЈЗ. Скопје.
16. Програмата за здравствена заштита на лица со душевни растројства во Р. Македонија за 2013 година. Влада на Република Македонија, 2012.
17. Националната стратегија за унапредување на менталното здравје во Република Македонија, 2005/2012 година. Национална комисија за заштита на менталното здравје, 2005.
18. WHO-AIMS Report on Mental health System in the Former Yugoslav Republic of Macedonia. WHO Country Office Skopje & WHO Regional Office for Europe 2009. https://cdn.who.int/media/docs/default-source/mental-health/who-aims-country-reports /macedonia_who_aims_report.pdf?sfvrsn=aa053851_3&download=true.
19. Law H, Neil ST, Dunn G, Morrison AP. Psychometric properties of the questionnaire about the process of recovery (QPR). *Schizophr Res* 2014; 156(2-3): 184-189. doi: 10. 1016/j.schres.2014.04.011.
20. Williams J, Leamy M, Bird V, Le Boutillier C, Norton S, Pesola F, *et al*. Development and evaluation of the INSPIRE measure of staff support for personal recovery. *Soc Psychiatry Psychiatr Epidemiol* 2015; 50(5): 777-786. doi: 10.1007/s00127-014-0983-0.
21. White S, Foster R, Marks J, Morshead R, Goldsmith L, Barlow S, *et al*. The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis. *BMC Psychiatry* 2020; 20: 534. https://doi.org/10.1186/s12888-020-02923-3.
22. Bond G, Drake R, Becker D. An update on Individual Placement and Support. *World Psychiatry* 2020; 19: 390-391. doi: 10.1002/wps.20784.
23. King T, Meddings S. Survey identifying commonality across international Recovery Colleges. *Mental Health and Social Inclusion* 2019; 23: 121-128. https://doi.org/ 10.1108/ MHSI- 02-2019-0008.
24. McCabe R, Saidi M, Priebe S. Patient-reported outcomes in schizophrenia. *Br J Psychiatry* 2007; 191(S50): s21-s28. doi: 10.1192/bjp.191.50.s21.
25. Thind A, Maly R. The surgeon-patient interaction in older women with breast cancer: what are the determinants of a helpful discussion? *Ann Surg Oncol* 2006; 13: 788-793. doi: 10.1245/ASO.2006.07.026.
26. Nordon C, Rouillon F, Barry C, Gasquet I, Falissard B. Determinants of treatment satisfaction of schizophrenia patients: results from the ESPASS study. *Schizophr Res* 2012; 139: 211-217. doi: 10.1016/j.schres.2012.05.024.
27. Cleary PD, McNeil BJ. Patient satisfaction as an indicator of quality care. *Inquiry* 1988; 25: 25-36. PMID: 2966123.
28. Fitzpatrick R. Surveys of patients' satisfaction: I – Important general considerations. *BMJ* 1991; 302: 887-889. doi: 10.1136/bmj.302.6781.887.
29. Ware Jr JE, Davies AR. Behavioral consequences of consumer dissatisfaction with medical care. *Eval Program Plann* 1983; 6: 291-297. doi: 10.1016/0149-7189(83)90009-5.
30. Rosen A, Killaspy H, Harvey C. Specialisation and marginalisation: how the assertive community treatment debate affects individuals with complex mental health needs. *Psychiatrist* 2013; 37(11): 345-348. doi: 10.1192/pb.bp.113.044537.
31. Catty J, Burns T, Knapp M, Watt H, Wright C, Henderson J, *et al*. Home treatment for mental health problems: a systematic review. *Psychol Med* 2002; 32: 383-401. doi: 10. 1017/s0033291702005299.

32. Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ* 2007; 335. doi: 10.1136/bmj.39251.599259.55.