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Title

Complementary and Alternative Medicine (CAM) in Danish residential homes for people with severe mental illness: Use and perceived benefits of CAM in relation to recovery

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Abstract:

Background and Aim: Mental health services in Denmark offer various rehabilitative treatment interventions to people with severe mental illness. Complementary and Alternative Medicine (CAM) such as National Acupuncture Detoxification Association (NADA) ear acupuncture are used as rehabilitative interventions. We investigated the use of CAM in four psychiatric residential homes, and whether CAM supports residents' rehabilitation and personal recovery.

Methods: Residents in four selected residential homes participated in a questionnaire study, which elicited information on the use of CAM offered in a residential home setting. The study was conducted from February to November 2017. Recovery scores were assessed using the Mental Health Recovery Measure (MHRM).

Results: Of 131 eligible respondents, 68 (52%) participated. CAM was used by 84 % of the residents. NADA ear acupuncture (38%) and music therapy (37%) were the most commonly used types of CAM.

Conclusions: CAM is a commonly used rehabilitative intervention and more than 50 % receiving treatment with CAM believed that it has supported their recovery process.

Keywords: Mental health, residential homes, complementary and alternative medicine, complementary therapies, recovery, MHRM, community mental health services

Introduction

Recovery from mental illness is a goal in psychosocial rehabilitation and a guiding principle in social policy and system reforms worldwide as well as in Denmark (Slade et al, 2014; Wilken & Hollander, 2008). Mental illness is no longer perceived as a chronic illness but as a condition from which one can recover. Models of organizational change to more recovery-oriented care has been developed in Denmark (Wilken & Hollander, 2008). In the last two decades, Danish Regions and Municipalities have implemented several supporting options with a recovery-orientated approach to rehabilitation (Region Hovedstadens Psykiatri, 2019). The rehabilitative effort aims at helping people with significantly impaired mental, physical, and social functioning to cope with everyday life (Eplöv, 2010).

A part of the psychiatric rehabilitative treatment takes place in residential homes, which offers psychiatric rehabilitation for periods of varying length. In contrast to the traditional medical approach to recovery, aiming at the elimination of clinical symptoms, rehabilitation efforts in residential homes are guided by the residents' personal recovery perspective, focusing on elements such as connectedness, hope, identity, meaning, and empowerment as described in the CHIME framework (Shanks et al., 2013). In a recovery-oriented approach employees need to pay more attention to the residents' personal values, meaning and purpose in life including spiritual and cultural experiences such as art, music, poetry, and nature (Slade et al, 2014). Spiritual activities such as meditation and yoga have become prevalent in our culture and is sometimes referred to as Complementary and Alternative Medicine (CAM) (Ahlin, 2013).

The use of CAM is popular among the Danish population (Ekholm, 2015). CAM includes e.g. massage therapy, music and art therapy and acupuncture. Literature describes CAM use in relation to pain relief, disease prevention, and to strengthen psychological balance and general well-being (Falkenberg et al., 2012). In general, people seek CAM as a part of managing illnesses and they typically combine traditional treatment with CAM on their own initiative (Ekholm, 2015).

CAM utilised by European citizens represents a variety of different medical systems and theories and are mainly used outside conventional health care (Falkenberg et al., 2012). In Denmark CAM is also used as a psychiatric rehabilitative intervention. A Danish survey found that CAM was an integrated part of treatment in about one in three institutions. (Salomonsen et al, 2011). In the United States, a national survey established that children and adults with psychiatric disorders were more frequent users of CAM than the rest of the population (Edwards et al, 2013).

The extent of CAM used for people with severe mental illness as a recovery-oriented intervention in Danish psychiatric residential homes has not yet been explored. Some studies suggest that systematic use of music therapy facilitate recovery (McCaffrey, 2018; McCaffrey & Edwards, 2016). A variety of benefits from ear acupuncture are also reported (National Acupuncture Detoxification Association/ NADA), such as relaxation, improved focus, and general alleviation of psychiatric symptoms (LaPaglia et al, 2016). However, limited knowledge exists about the use of CAM in recovery-oriented care worldwide and in Denmark, only small-scale internal evaluations of the effects of such treatments has been performed (Collinge et al., 2005; Russinova et al, 2009).

The aim of this present study is to investigate the use of CAM in a Danish Psychiatric residential home setting, and whether CAM supports the rehabilitative treatment and personal recovery. The study specifically aimed to answer the following questions:

- 1) What types of CAM are offered in four psychiatric residential homes?

- 2) What kinds of CAM activities are used by the residents?
- 3) Does CAM support the recovery process?

Methods

Design and setting

The current study is a cross-sectional study including data from four selected residential homes (RH), who all accepted the invitation to participate. Two RH's were located in the southern part of Jutland, and two in central Jutland. All four RH's were selected because they offered a long or temporary stay and provided a wide range of CAM services'.

The target group living at the RH's were adults with mental disorders aged 18-40 +, with severe psychiatric illness, as well as social disability and a need for daily support. Approximately, between 18 - 45 people were living in each RH, in one or two- room apartments with or without bath and kitchenette. There were shared facilities for CAM- activities, treatment and socializing. Staff were present 24/7 facilitating activities in relation to daily living and rehabilitation.

Staff were recruited from a range of professional backgrounds. Half were holding a professional bachelor degree in nursing, occupational therapy or pedagogy and the other half were trained as social or healthcare assistants. Many staff members were competent in CAM, having supplementary training in massage, acupuncture or others. Each RH's offered different types of CAM depending on staff competences.

Recruitment of participants

All residents at the four RH's were invited to participate in the study. In total, 131 individuals were eligible for participation as no participants were excluded. They all received written and oral information. The participation in the project was voluntary and participants did not receive any compensation for participating. Data were collected between February and November 2017.

Measurements and data collection

The questionnaire contained information on sex, age, self-defined psychiatric diagnosis and time living in the RH. Further questions concerned the respondent's use of CAM within the last three months (inside or outside the RH) and their use of CAM prior to moving into the RH. Respondents could select more than one answer. We used a broad approach to identify CAM used at the four RH's to relieve or treat physical or mental illness as suggested by Falkenberg et al (Falkenberg et al., 2012). The CAM items on the questionnaire were inspired by the Danish Health and Illness Survey 2013 and included items like: music therapy, massage, NADA ear acupuncture, nutritional counselling, yoga, mindfulness and the item "Others" were also available (Ekholm, 2015). To explore the recovery relevant perceived benefits of CAM, we asked the respondents to provide reasons for using CAM by selecting at least one of six statements, such as "*To improve emotional*

well-being”, “*stimulate hope and optimism*”, and other options were available. These items were inspired by the study of Molassiotis et al. (Molassiotis et al, 2005).

The recovery score was assessed by using the Mental Health Recovery Measure (MHRM) questionnaire (Toledo University, 2009). This 30-item measure assessed the individual recovery process of people suffering from severe mental illness. It is translated and validated for use in several populations, including the Danish speaking. Individual recovery score calculations were based on the total MHRM recovery score. In an American context, the mean score, across different groups of people with mental disorders, is 80 points (sd 20). The theoretical range for the total score is 0–120; with higher scores indicating better recovery (Toledo University, 2009).

In the last section of the questionnaire the residents were asked to assess on a 5-point Likert scale from “Strongly agree” to “Strongly disagree” whether they agreed that CAM would strengthen their recovery process. It was also possible to answer, “Don’t know” to this item.

Within a month, the questionnaire was distributed through the web or handed out to all 131 eligible respondents. Staff and the first author were available for assistance completing the questionnaire.

Ethics

In accordance with the Helsinki Declaration, full confidentiality was obtained and anonymity assured in all phases of the research project. All participants received adequate information about the study and the researchers involved and were informed that they could withdraw from the study at any time without any repercussions. The project was reported to the Danish Data Protection Agency (journal no. 2015-57-0008) and the data collection was not initiated before approval had been gained. Data were processed and stored in accordance with the recommendations of VIA University College for safe data storage.

Statistical analysis

Descriptive statistics were used to describe the respondents and explore differences between their demographic characteristics using a one-way test for continuous variables and χ^2 -tests for discrete variables. The CAM offers and the residents’ use of CAM were presented as numbers and percentages. The MHRM was used to calculate a total mean recovery score for each residential home and a mean recovery score for all four residential homes. As the total MHRM recovery score was normally distributed, we calculated a crude mean difference in relation to CAM-users and CAM-non users, using multiple regression analyses. The association was first tested in a crude model, and then in an adjusted model with potential covariates (sex, age, years living with mental illness, time living in the RH and the RH). The significance level was $p < 0.05$.

All the analysis was conducted using STATA software (StataCorp. 2017. Stata Statistical Software: Release 15. College Station, TX, USA: StataCorp LLC).

Results

Sample characteristics

Sixty-eight of the 131 eligible residents agreed to participate in the study (52%). The demographic characteristics of the respondents in relation to RH's are presented in table 1.

Table 1. Demographic characteristic of respondents in four residential homes (RH)	RH 1 (n = 10)	RH 2 (n = 21)	RH 3 (n = 21)	RH 4 (n = 16)	P-value
Sex, women n (%)	5 (50%)	13 (62%)	7 (35%)	9 (56%)	0.28
Age, mean in years (sd)	41.6 (18.1)	38.2 (11.6)	52.4 (13.1)	42.3 (17.2)	0.01
Years having a mental diagnosis; mean in years (sd)	10.8 (9.9)	15.7 (10.5)	25.2 (15.9)	19.2 (15.3)	0.03
Self-defined diagnosis, n (%)					
Schizophrenia	7 (70%)	13 (62%)	15 (71%)	7 (44%)	0.09
Bipolar disorder	1 (10%)	0	3 (14%)	4 (25%)	
Personality disorder	1 (10%)	3 (14%)	2 (10%)	3 (19%)	
Depression	2 (20%)	1 (5%)	2 (10%)	7 (44%)	
Schizoaffective disorder	1 (10%)	-	1 (5%)	-	
ADHD*¹	1 (10%)	1 (5%)	-	4 (25%)	
Autism	-	5 (24%)	-	2 (13%)	
Other*²	1 (10%)	3 (14%)	3 (14%)	6 (38%)	
Don't know	-	-	1 (5%)	-	
Years in residence (%)					0.36
< 1 years	-	3 (14%)	2 (10%)	3 (19%)	
1–5 years	6 (60%)	10 (48%)	5 (24%)	5 (31%)	
6–10 years	2 (20%)	3 (14%)	7 (33%)	2 (13%)	
11–15 years	-	3 (14%)	3 (14%)	1 (6%)	
16–20 years	1 (10%)	-	2 (10%)	1 (6%)	
> 20 years	-	2 (10%)	-	3 (19%)	
Other*³	1 (10%)	-	2 (10%)	1 (6%)	
Don't know	-	-	-	-	

*¹ Attention deficit hyperactivity disorder *² Post traumatic stress disorder, obsessive compulsive disorder, eating disorder, anxiety. *³ Support centre

Overall, the two sexes were equally represented. The mean age of all participants was 44.1 years and the highest mean age was represented at RH 3 with an average of 52.4 years (range from 27–69 years, sd 13.1). We found significant differences across the four residential homes with respect to the participants' age ($p = 0.01$) and time living with a mental diagnosis ($p = 0.03$). Most residents reported more than one psychiatric diagnosis. Schizophrenia was the most common self-defined diagnosis.

Compared to length of stay in the residential home, RH 2 and RH 4 reported 10% and 19% of the respondents that they have stayed in the residential home for more than 20 years.

Offers and use of CAM in four residential homes

The RH's offered different types of CAM. All CAM offers were a supplement to the traditional rehabilitation interventions such as housing support and psychiatric milieu therapy (Gunderson, 1978). The CAM offers depended on staffs competencies in relation to CAM.

RH 1 did not offer mindfulness, yoga, respiratory therapy and body therapy, while RH 3 did not offer yoga (table 2). All the RH had staff educated in NADA ear-acupuncture and all RH used music for recovery purposes, but only in RH 3 a trained music therapist provided this intervention.

NADA ear acupuncture was reported as the most frequently used CAM (38%), followed by music therapy (37%) and massage (32 %). Overall, spiky massage ball and singing bowls massage were also common and used by 18% (Table 2). The residents used CAM both as an ad hoc supplementary offer and as part of a more systematic process. In general, 16 % (n=11) of the respondents had never used CAM (Table 2).

Table 2. CAM offers and residents' use of CAM in four RHs	In all (4 RHs)	RH 1	RH 2	RH 3	RH 4
	% (n)	% (n)	% (n)	% (n)	% (n)
NADA (ear acupuncture)	38% (26)	30% (3)	43% (9)	40% (8)	31% (5)
Music therapy and music	37% (25)	40% (4)	10% (2)	80% (16)	13% (2)
Massage	32% (22)	60% (6)	62% (13)	10% (2)	6% (1)
Art therapy	26% (18)	20% (2)	24% (5)	25% (5)	38% (6)
Nutritional counselling	18% (12)	10% (1)	19% (4)	5% (1)	38% (6)
Mindfulness	13% (9)	-	10% (2)	25% (5)	6% (1)
Respiratory therapy and body therapy	10% (7)	-	10% (2)	15% (3)	6% (1)
Yoga	9% (6)	-	24% (5)	-	6% (1)
Others*1	18% (12)	30% (3)	19% (4)	5% (1)	25% (4)
No treatment	16% (11)	10% (1)	10% (2)	10% (2)	38% (6)
*1 Spiky massage ball and Singing bowls massage					

CAM as a supportive recovery intervention

Looking at the total MHRM mean recovery score (table 3) respondents in RH 2 (n = 21) had the lowest recovery score, with a mean score of 62.2 points (sd 21.9). The highest total MHRM recovery score was reported by respondents in RH 3 (n = 21), whose mean score was 74.9 points (sd 12.9). However, the differences in total MHRM mean recovery scores across the four residences were not statistically significant (p = 0.16).

	RH 1 (n = 10)	RH 2 (n = 21)	RH 3 (n = 21)	RH 4 (n = 16)	P-value
MHRM Total, mean (sd)	70.3 (9.9)	62.2 (21.9)	74.9 (12.9)	66.9 (22.9)	0.16

While 57 residents had used CAM in the RH's, 11 respondents did not use CAM at all (Table 4). Comparing CAM users with CAM non-users in relation to the total MHRM recovery score, the recovery mean score were lower in the group of CAM users (67,5 points) compared to the group of CAM -non users (73,3 points), but the adjusted mean difference was statistically insignificant (4.2 points 95% CI (-9.4:17.8) p = 0.54) (Table 4).

	N	Recovery Mean (se)	Unadjusted recovery score Mean difference (95% CI)	P-value	*Adjusted recovery score Mean difference (95% CI)	P-value
CAM user	57	67.5 (2.5)	5.7 (-18.1:6.5)	P =	4.2 (-9.4:17.8)	P =
CAM non-user	11	73.3 (5.2)		0.35		0.54

***Adjusted for sex, age, years with mental illness, years living in the residential home, and residential home**

Although we found no statistically significant correlation between residents use of CAM in relation to the total MHRM recovery scores (Table 4), figure 1 shows the respondents' level of agreement concerning whether CAM had strengthened their recovery process. Forty per cent indicated their "strong" agreement with the statement that CAM had strengthened their recovery process, while 19% responded that they "agreed". Twenty-four per cent said they didn't know, while only 4–7% said either they disagreed, were neutral, or strongly disagreed with the statement.

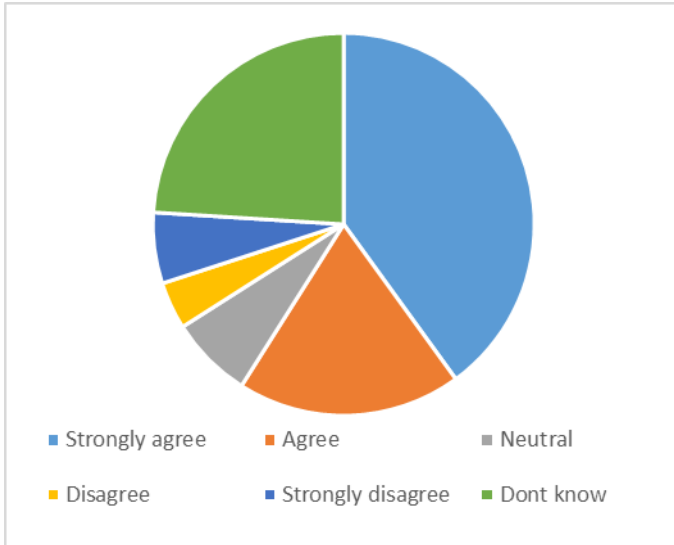


Figure 1: Do you agree that CAM helps and strengthens your recovery process?

All residents n = 68

Investigating the respondents' motivation for using CAM, the respondents could tick all statements indicating a fit (table 5).

Table 5. Respondents' stated reasons for using CAM	Respondents (n)%
It might help and won't hurt me to try it out	28 (43%)
To improve physical well-being	28 (43%)
To improve emotional well-being, stimulate hope and optimism	27 (42%)
To obtain an effect on my mental illness	26 (40%)
To actively do something	22 (34%)
To do everything possible to alleviate the symptoms of my mental illness	22 (34%)
Other*	22 (34%)

*To sleep better, reduce anxiety, improve energy levels, reduce medication, to relax

The use of CAM was typically motivated by the respondents' belief that *"It might help and won't hurt me to try it out"* or *"To improve physical well-being"* (43%); almost as many cited their wish to *"To improve emotional well-being, stimulate hope and optimism"* (42%). Roughly one in three stated, *"To actively do something"*, *"To do everything possible to alleviate symptoms"*, or *"Other"* as among their reason (each 34%) (Table 5).

Discussion

The study shows that different types of CAM were offered in the four investigated residential homes. All residential homes used NADA ear acupuncture, music/ music therapy, massage, art therapy and nutritional counselling, while yoga, mindfulness and respiratory therapy was not commonly offered.. Eighty- four per cent (n = 57) of the residents had used one or more types of CAM offered in the residential home. The most commonly used CAM were NADA ear acupuncture (38%), followed by music or music therapy (37%), and massage (32%).

We were unable to find similar studies in Denmark or elsewhere investigating the use of CAM in a RH setting in relation to recovery. The exploration of the use of CAM in Denmark has typically involved people with severe illness, such as cancer or sclerosis (Pedersen et al, 2009; Skovgaard et al, 2013). A nationwide sample of newly diagnosed breast cancer patients shows that 40.1% of Danish patients had used at least one type of CAM since the time of diagnosis, with dietary or vitamin supplementation being the most common, followed by herbal therapy. A total number of, 33.7% indicated their belief that CAM would have a positive influence on their breast cancer (Pedersen et al, 2009).

In a large survey of people with severe mental illness in 25 countries, 3.6% reported use of CAM during the last twelve months. Use of CAM was most common in high-income countries and by individuals receiving conventional care (Jonge et al, 2018). Single studies and surveys conducted elsewhere have demonstrated that people with severe psychiatric illness use various CAM, such as religious and spiritual activities, meditation, massage and herbs to achieve physical, cognitive, and emotional benefits (Russinova et al, 2009). None of these studies examines CAM use in relation to a recovery perspective. Russinova (2002) found that 52 of 68 respondents believed that meditation improved their ability to maintain emotional calmness, a feeling of grounding, and an experience of inner strength, and that it led to improved concentration (Russinova et al, 2002).

Perceived benefits of CAM in relation to recovery

Our study was designed as a cross-sectional study, which did not explore the effects before and after an intervention. As the total MHRM mean score represented only a single measurement, no change over time could be detected. In general, the average MHRM total recovery score, across different groups of people with mental disorders, is 80 points (sd 20) (Toledo University, 2009), indicating that our residents total MHRM recovery score were lower ranging from 62.2 (sd 21.9) to 74.9 (sd 12.9) points. Comparing CAM-users with CAM-non-users in respect to the total mean recovery score we found that the total mean recovery score among CAM users were 4.2 points lower compared to CAM-non-users (taking different confounders in consideration). The result may seem like a paradox, since one would have expected CAM-use to increase the recovery score. CAM- users use CAM to increase the sense of inner comfort and to increase hope. Therefore, the result might indicate that residents are using CAM because they believe and need CAM to improve the recovery process by feeling physical and emotional wellbeing. Nearly six out of ten (59%) residents declared that they felt certain or relatively certain of the positive effect on recovery, whereas 24% answered “don’t know”. The most commonly stated reasons for using CAM in the RH setting were to reduce physical and emotional symptoms and because “CAM might help and

won't hurt". In terms of recovery these statements are related to themes of personal recovery such as hope, promoting basic function and feeling of control related to emotional wellbeing and inner comfort and containment. The statements might suggest that benefits of CAM activities were associated with experiences concerning major areas of promoting physical and basic functioning and emotional wellbeing among our residents. CAM is seen as beneficial related to recovery because it increases the sense of well-being, emotional control and hope, as it helps residents improve their basic functioning and inner comfort due to reduction in physical and psychological symptoms of mental illness; it also appears to provide spiritual help by inspiring hope and belief. Our results corroborate the findings of Russinova et al. 2009, who found that patients believe that CAM improves their physical, emotional, social, and spiritual functioning as well as reducing the severity of symptoms and promoting recovery (Russinova et al, 2009).

Limitations

A number of limitations of our study needs to be addressed. Our study was designed as a cross-sectional study with a single point of data collection; our results reflect an immediate image of the residents' use of CAM, and perceived benefits in relation to recovery. We used the MHRM as a recovery outcome measure. Mostly, the MHRM recovery questionnaire is used to measure changes in recovery scores before and after an intervention. Our study presented residents' recovery score as an immediate score not indicating perceived benefits of CAM during a period of time. In future studies it might be beneficial to investigate benefits of CAM in relation to recovery in a CAM - intervention study measuring changes in relation to recovery over time or investigate other outcomes in relation to CAM such as quality of life.

Differences in our data collection methods may also have contributed to information bias. In some RH's the residents completed the questionnaire without help; in others, they were assisted by staff or the first author, which may have affected responses, although the questionnaire did not directly address issues related to staff or the residential homes.

Participation in the study may suffer from selection bias. We were unable to analyse for nonparticipation because participation was voluntary and anonymized; thus, we cannot say whether the use of CAM was less widespread among nonparticipants, or whether nonparticipants were in a later stage of recovery than the participants were. Nonparticipation could also reflect poor recovery, although the chosen questionnaire format allowed even the frailest residents to participate, as they could take as much time as needed for response.

To our knowledge, this is the first study to investigate the use of CAM as a rehabilitative intervention in a psychiatric residential home setting in Denmark. We were unable to identify any studies in other countries investigating the use of CAM, which points to a lack of knowledge in this field. Our work has generated further topics of interest, such as the perceived effects of specific CAM interventions.

Conclusion

CAM is a regular intervention in the rehabilitative treatment offered to severely mentally ill people in Danish RH's. NADA ear acupuncture is the most frequently used therapy. The majority of our respondents used only the CAM's offered in the RH, believing that it strengthened their recovery process. CAM was mainly used to minimize physical and emotional symptoms.

Although our data collection method did not demonstrate that use of CAM accelerates the recovery process, our study suggests that CAM may help residents recover, as one of its perceived benefits was the experience of improved physical and mental well-being among users.

The study has generated further questions for research into how CAM can strengthen the rehabilitative treatment of people with severe mental illness.

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