

**POLICY**

**SAINSBURY CENTRE**  
for MENTAL HEALTH  
removing barriers achieving change



# **Making Recovery a Reality**

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## The Principles of Recovery

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward.
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No 'one size fits all'.
- The helping relationship between clinicians and patients moves away from being expert / patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be "on tap, not on top".
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.
- Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.
- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.
- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.
- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

Adapted from *Recovery – Concepts and Application* by Laurie Davidson, the Devon Recovery Group. We gratefully acknowledge his permission to use this material.

## Service user quotes

Throughout this paper we will be using quotes from service users collected as part of a research study by the Scottish Recovery Network (Brown & Kandirikirira, 2007). We gratefully acknowledge their permission to use this material.

## Introduction

*“Two or three years ago I realised that you really could recover...I thought that once you had it, that was it – but you can recover. I find that quite an amazing fact...”*

‘Recovery’ is an idea whose time has come. At its heart is a set of values about a person’s right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of ‘hope’ in sustaining motivation and supporting expectations of an individually fulfilled life.

Recovery provides a new rationale for mental health services. It has become the key organising principle underlying mental health services in New Zealand (Mental Health Commission, 1998), the United States (Department of Health and Human Services, 2003) and Australia (Australian Government, 2003). Closer to home, it has been adopted in Ireland (Mental Health Commission, 2005) and Scotland (Scotland Government, 2006).

The ideas behind recovery are also supported in England by various Department of Health policies which aim to promote self-management of long-term conditions and ‘choice’. These include *The Expert Patient* (Department of Health, 2001); *Our Health, Our Care, Our Say* (Department of Health, 2006a); and the *Commissioning framework for health and well-being* (Department of Health, 2007a).

Several leading mental health trusts in England are also now beginning to incorporate recovery ideas into their principles of operation (e.g. Devon Partnership NHS Trust, 2007; South London & Maudsley NHS Foundation Trust, 2007; South West London and St George’s Mental Health NHS Trust, 2007).

In terms of professional support, the Chief Nursing Officer’s recent review of mental health nursing recommended that the key principles and values of the recovery approach should inform all areas of mental health nursing practice (Department of Health, 2006b).

Similar support has been given by the College of Occupational Therapists (2006) and the British Psychological Society Division of Clinical Psychology (2000). The Royal College

of Psychiatrists, the Social Care Institute for Excellence and the Care Services Improvement Partnership have also recently endorsed the concept of recovery in an important position paper, *A common purpose* (RCP / SCIE / CSIP, 2007) launched at the Royal College of Psychiatrists annual conference in Edinburgh 2007.

We believe that the concept of recovery requires further development, but that it provides a framework which, if seriously adopted, will bring a radical transformation of mental health services in this country in the future. This policy paper presents some of the key ideas and examines their implications for the delivery of mental health services. It is not the last word on the topic of recovery; rather it aims to open up debate about how the recovery approach can be put into practice and what services need to do to make it happen.

## Defining recovery

*“I have taken ownership of my illness and I take responsibility for what I do and do not do. I don’t let it control me...It’s not the whole of my life, it’s just a part of my life now...”*

‘Recovery’ is something of a contested term. However, a widely agreed definition would be along the lines given by one of the intellectual founders of the recovery movement, Bill Anthony:

*“[Recovery is] a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness...”*

(Anthony, 1993)

Recovery ideas have been largely formulated by, and for, service users to describe their own life experiences. Professionals should therefore be sensitive about accusations that they are trying to ‘take them over’. Nevertheless, we believe that for recovery to have the impact it deserves, professionals need to understand what it means and, together with service users and others, actively support its implementation across services.

What are the essential elements? After studying personal accounts of recovery, Andresen, Oades & Caputi (2003) suggested four key components. These are shown in Box 1. They are very similar to the elements proposed by Rethink (2008).

**Box 1: Components of the process of recovery**

- I. **Finding and maintaining hope**  
– believing in oneself; having a sense of personal agency; optimistic about the future;
- II. **Re-establishment of a positive identity** – finding a new identity which incorporates illness, but retains a core, positive sense of self;
- III. **Building a meaningful life** – making sense of illness; finding a meaning in life, despite illness; engaged in life;
- IV. **Taking responsibility and control**  
– feeling in control of illness and in control of life.

(after Andresen, Oades & Caputi, 2003)

A central tenet of recovery is that it does not necessarily mean cure ('clinical recovery'). Instead, it emphasises the unique journey of an individual living with mental health problems to build a life for themselves beyond illness ('social recovery'). Thus, a person can recover their life, without necessarily 'recovering from' their illness.

As with physical health problems, people have to come to terms with the trauma that the occurrence of mental health symptoms can have on their lives and incorporate these experiences into a new sense of personal identity. What has happened to me? What does it mean? Why has it happened? These questions arise at whatever age symptoms first occur, but are particularly problematic for young people, whose sense of identity is still forming (Larsen, 2004).

They can only be resolved if the person can discover – or rediscover – their sense of personal control ('agency') and gain a belief in the future (hope). Without hope they cannot begin to build their lives. Recovery is about this process and the *quality* of this experience is therefore central.

In mental health services, recovery ideas have received most attention in relation to the experiences of adults, but they can be applied

to anyone who experiences a significant mental health problem at any age. They can also be applied in specialist areas such as forensic mental health services, brain disorders and drug and alcohol problems.

In the physical health field they can be applied to any long-term health problem: asthma, diabetes, rheumatoid arthritis, cardiac disease, etc. and the management of these conditions now relies heavily on the provision of information and self-management in addition to treatment and symptom control.

**The origins of recovery**

*"...Over the years, psychiatrists and people, no one actually says, 'You can recover'. It's never mentioned..."*

Many of the ideas underpinning the recovery philosophy are not new. The main impetus comes from the consumer / survivor movement in the 1980s and 1990s. This was based on self-help, empowerment and advocacy. It provided a challenge to traditional notions of professional power and expertise which pervaded mental health services (and arguably still do). These ideas themselves had their roots in the Civil Rights movements of the 1960s and 1970s in the US and in self-help groups such as Alcoholics Anonymous where the concept of being 'in recovery' remains a central tenet.

Recovery ideas were then given a strong impetus in the 1980s by evidence emerging from studies of the long-term outcomes of people with serious mental health conditions like schizophrenia. They challenged the idea that people would inevitably deteriorate and demonstrated a wide range of different outcomes. The research found that between a quarter and two-thirds of people experiencing a psychosis for the first time made a partial or full recovery: defined as an amelioration of symptoms to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social and vocational activities (Davidson & McGlashan, 1997).

Most people with severe and long-term disorders can therefore realistically look forward to 'clinical recovery' and less than a quarter are likely to remain permanently disabled. Even then, 'social recovery' is not impossible as they may still

achieve a better understanding of how to manage their symptoms and to build a meaningful life, despite greater limitations.

Many recovery ideas have an even longer pedigree. There are echoes with the concept of ‘moral treatment’ as practised in the early institutions, inspired by the example of the York Retreat (Digby, 1985). There are also some parallels with the ‘Therapeutic Community’ movement which drove the reforms of the old institutions after the Second World War (Clark, 1974). Both these approaches emphasised the importance of humane treatment, self-help, peer support and the value of work and other structured activities. In this country, recovery also has connections with the rehabilitation tradition, led by psychiatrists like Douglas Bennett (Bennett, 1978; Shepherd, 1984; 1991).

Rehabilitation is now in a process of redefining itself to incorporate recovery ideas (Roberts *et al.*, 2006). It has retained a preoccupation with social, as opposed to medical, outcomes, but there is an increasing emphasis on self-management and a ‘strengths’ approach focusing on what people can do, rather than what they can’t (Rapp & Goscha, 2006). The importance of maintaining hope and high expectations have also become much more prominent (Perkins, 2006). Thus, recovery provides a new conceptual framework for modern rehabilitation practice.

## Recovery-oriented services

Rehabilitation is not the only area of mental health services that is beginning to redefine itself. According to the Government’s National Director of Mental Health:

*“Increasingly, services aim to go beyond traditional clinical care and help patients back into mainstream society, re-defining recovery to incorporate quality of life – a job, a decent place to live, friends and a social life”*

(Appleby, 2007a).

This affirms the importance of ‘social exclusion’ as a contributory factor in the occurrence and persistence of mental health problems (Social Exclusion Report, 2004); and of ‘social capital’ as a possible preventative factor (De Silva *et al.*, 2005; Falzer, 2007). In policy terms, it means that mental health services need to become much more concerned about overall health and wellbeing and providing direct support to enable people

to function as full citizens in their communities (Department of Health, 2007a).

The objectives of ‘recovery-oriented mental health services’ are therefore different from the objectives of traditional, ‘treatment-and-cure’ health services. The latter emphasises symptom relief and relapse prevention. In recovery, symptomatic improvement is still important, and may well play a key role in a person’s recovery, but quality of life, as judged by the individual, is central. The most powerful evidence for recovery therefore lies in the narrative accounts of individuals (e.g. Leete, 1987; Deegan, 1996) rather than in changes in the severity of symptoms over time.

## The role of professionals

The recovery approach also requires a different relationship between service users and professionals. Roberts & Wolfson (2004) have characterised this as a shift from staff who are seen as remote, in a position of expertise and ‘authority’, to someone who behaves more like a personal coach or trainer: *“offering their professional skills and knowledge, while learning from and valuing the patient, who is an expert-by-experience”*. This is based on openness, trust and honesty and it is the quality of this helping relationship that is crucial.

The aim of the professional is thus to provide the person with the resources – information, skills, networks and support – to manage their own condition as far as possible and to help them to get access to the resources they think they need to live their lives. This is entirely consistent with the orientation described in *New Ways of Working* (Department of Health, 2007b). Repper and Perkins (2003) have neatly summarised this change as professionals being, “on-tap, not on-top”. It implies a very different power relationship between professionals and the people they are there to serve.

The process of recovery is then fuelled by ‘hope’ (Perkins, 2006). This need not mean that in recovery services everyone must always remain ‘hopeful’ even in the face of what seem to be insurmountable practical problems. While it is true that recovery approaches do generally believe that the individual’s hopes and dreams are often more important than professional judgements about what is ‘realistic’, they do not encourage naïve unrealism.

In some ways, this is simply pragmatic. A person's hopes and expectations *are* usually a bigger influence on their behaviour than what professionals think. It also has to be acknowledged that professionals are often rather bad at making accurate predictions of what is and is not likely to be possible for a given individual in a specific area of their life and there is a consistent danger that professionals will underestimate people's potential. Low expectations can all too easily then become self-fulfilling prophecies (Social Exclusion Unit, 2004).

But recovery does not make a professional's opinions worthless. Nor should professionals pretend that something is possible when they genuinely believe it is not. However, professionals should remember that they can sometimes be wrong and they must recognise that there is an intrinsic value in supporting people in trying to achieve the goals they set for themselves, even if they think that these goals are not 'realistic'.

If symptom change is a secondary goal, the help provided by professionals and services other than mental health becomes much more important.

*"Any services, or treatments, or interventions, or supports must be judged in these terms – how much do they allow us to lead the lives we wish to lead?"*

(Repper & Perkins, 2003).

Housing, employment, education and participation in 'mainstream' community and leisure activities then become the central objectives, not just things that professionals hope will happen if the person is 'cured'. Treatments, whether physical, psychological or social, are useful only insofar as they assist with these aims. This turns the traditional priorities of mental health services 'upside down'.

## The recovery journey

*"Have a vision of where you want to be and try to find ways of getting there... Nothing should ever stop you from being what you want to be.... Don't ever let anyone tell you. It's not their life, it's your life..."*

While 'recovery' is an option for everyone, it may not be taken up to the same extent by every individual (and that is their 'choice'). Andresen, Caputi and Oades (2006), on the basis of extensive interviews with service users, suggest five 'stages' of the recovery process. These are shown in Box 2.

### Box 2: The five stages of recovery

- **Moratorium** – A time of withdrawal characterised by a profound sense of loss and hopelessness;
- **Awareness** – Realisation that all is not lost and that a fulfilling life is possible;
- **Preparation** – Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills;
- **Rebuilding** – Actively working towards a positive identity, setting meaningful goals and taking control of one's life;
- **Growth** – Living a meaningful life, characterised by self-management of the illness, resilience and a positive sense of self.

(from Andresen, Caputi & Oades, 2006)

The 'stages' in Box 2 should not be seen as a linear progression that everyone has to go through. They are better seen as aspects of engagement with the recovery process. So, why doesn't everyone engage to the same degree?

Davidson & Roe (2007) suggest that many people may appear unwilling to engage with recovery because of the severity of their symptoms, their negative experiences of mental health care, the intolerable side effects of medication, or the simple fact that it is sometimes too painful and costly for them to begin to acknowledge that they need the kind of help that is being offered. It is

vital that services support these individuals in beginning their recovery journey.

In the first place, staff must be willing to listen. ‘Listening’ is a much under-rated skill and, although it may be uncomfortable, it is often very valuable to be prepared simply to sit and listen while the person attempts to make sense of their experience of upset and distress. (It may also be painful for professionals to listen to the service user’s perceptions of a previously uncaring mental health service.) The person may then be encouraged to write down their symptoms and coping strategies and, by focusing on small steps for change, increase their sense of self-control over distressing events (Perkins, 2007).

As this process builds, the person may work towards the formulation of a joint ‘crisis plan’, involving both their care coordinator and their psychiatrist. These are like ‘advance directives’, but explicitly involve the whole treatment team and have been shown to have a significant effect on reducing involuntary admissions (Henderson *et al.*, 2004).

Thus, if professionals can start to step back a bit, to share power and acknowledge the contribution of ‘experts-by-experience’ – users and carers – then all parties can benefit. If the person can achieve greater control over their symptoms and how they are managed, particularly during times of crisis, they can begin to grow in confidence and take control over other aspects of their life.

## The importance of work and employment

*“The hardest thing about having a mental illness is the feeling that you’re constantly taking, that people are always giving to you, that people are always supporting you... Recovery has been about actually looking at ways I can give back to other people that I care about...”*

One of the most important indicators of progress is when the person is able to step outside the ‘sick role’ and become more than simply a passive recipient of care. Whether it is through work, through caring for family or friends, or simply through finding that by sharing your life story you can provide hope and inspiration to others, this is often a key step in the recovery process.

Work and employment remain the primary means through which people connect with their communities and build their lives. Finding you have ‘something to give’, as well as needing help, is central to building a positive sense of self-esteem and this is at the heart of recovery.

Of course, there is a danger that ‘work’ will be seen as a panacea. There is also a fear that government enthusiasm to reduce numbers of people claiming incapacity benefits will force people with mental health problems back into the employment market, adding to their distress rather than alleviating it.

There is clearly an important balance to be struck here between the dangers of forcing people back to work and the dangers of excluding them from it through a combination of ignorance, prejudice, and lack of effective help. We believe the greater dangers still lie on the side of exclusion. There is certainly extensive evidence that most people with mental health problems want to work, if only they can be provided with the right kinds of help and support (Seebohm & Secker, 2005). If recovery is to become a reality, employment must become one of its key priorities.

## Carers, relatives and friends

Mental health problems have a profound effect not only on the life of the person who experiences them, but also on those who are close to them. Carers, relatives and friends often provide most of the individual’s support and may have a critical role in promoting recovery and facilitating social inclusion. If they are to do this effectively, they need to understand the person’s situation and the challenges ahead and receive the necessary support to help them in their recovery journey.

However, relatives, carers and friends still often feel ill-informed and unsupported. Some carers also continue to believe that professionals implicitly – or at times explicitly – blame them for their relative’s problems. These are not good conditions for the development of effective ‘partnerships of care’ (Repper *et al.*, 2007).

Family and friends also face the challenge of making a recovery in their own right. They too have to re-evaluate their lives, by coming to terms with what has happened and making the necessary adjustments. Relatives, carers and friends must discover new sources of value and meaning for

themselves, both in their own right and in their relationship with their loved one. Too often informal carers find their own social networks, contacts and opportunities diminished and find that they too experience stigma and social exclusion.

It is therefore important that mental health services also facilitate the recovery of carers and people who are close to the person, helping them to make sense of what has happened, to rebuild their own lives and to get access to the opportunities that they value.

### Obstacles to recovery-oriented practice

*“I’m not stupid you know. I may be depressed, I may be withdrawn, I may be psychotic, but I’m not like that all the time...”*

Despite their popularity and intrinsic attractiveness, recovery ideas have not been without their critics. There are already signs of a consumer ‘backlash’ against recovery ideas: which are seen by some as simply a rationale for cutting services, reducing benefits and forcing people back to work. These are understandable fears but, in our view, they should not be allowed to obscure the value of recovery ideas and their potential to transform mental health services for the better.

Some of the most widespread criticisms of the recovery approach are summarised by Davidson *et al.*, (2006). These are listed below.

1. *“Recovery is old news. What’s all the hype? We’ve been doing recovery for years.”*  
 There are some familiar ideas in recovery, but since it is concerned with longstanding (and difficult) human problems perhaps this is not surprising. Although there is little in mental health services that is really ‘new’, we would argue that ‘recovery’ is sufficiently distinctive to justify its inclusion as a new concept with important new implications.
2. *“Recovery-oriented care adds to the burden of mental health professionals. You mean that I not only have to care for and treat people, but now I have to do recovery too?”*  
 Recovery need not create extra burdens if it replaces existing ideologies. There is an obvious danger of adding to staff workloads if recovery-oriented care were simply to be

‘added on’. However, the argument here is that recovery models should *replace* traditional ‘assessment-treatment-cure’ ideologies in mental health services. In this way they should not add to the burden of over-stretched professionals: indeed, they might be argued to take some things away.

3. *“Recovery means that the person is cured. What do you mean your clients are in recovery? Don’t you see how disabled they still are? Isn’t that a contradiction?”*  
 No. Recovery is about the person and their life. What happens to their ‘illness’ is a different question. ‘Cure’ and ‘recovery’ are not the same thing, even though active treatment may be an essential element in the recovery process.
4. *“Recovery happens for very few people with serious mental illness. You’re not talking about the people I see. They’re too disabled. Recovery is not possible for them.”*  
 No. Recovery is possible for everyone. However, not everyone will be ready – or willing – to engage in it in the same way. People have to choose their own recovery path. It is the role of others (including professionals) to ensure that the person is never discouraged from believing that they should pursue their own hopes and aspirations.
5. *“Recovery in mental health is an irresponsible fad. This is just the latest flavour of the month and one that sets people up for failure.”*  
 No. It is probably the most important new direction for mental health services. Recovery represents the convergence of a number of ideas (empowerment, self-management, disability rights, social inclusion and rehabilitation) under a single heading that signals a new direction for mental health services. Recovery is not going to disappear overnight.
6. *“Recovery only happens after, and as a result of, active treatment and the cultivation of insight. My patients won’t even acknowledge that they’re sick. How can I talk to them about recovery when they have no insight about being ill?”*  
 No. Treatment and gaining an understanding of oneself and one’s illness go hand-in-hand with recovery. As already indicated, ‘active treatment’ may well be an important part of recovery. There is nothing inconsistent in this. ‘Insight’ is a highly contentious concept. It is



not an ‘all-or-nothing’ state and no one has a monopoly on it. ‘Insight’ is less important than how the person evaluates different aspects of their life.

7. *“Recovery can be implemented only through the introduction of new services. Sure, we’ll be happy to do recovery, just give us the resources /money /staff.”*

No. We already have a raft of policies in mental health which support the recovery approach. We really don’t need any new policies or services, we just need to make existing services work more effectively, more directly driven by users’ needs, with a clear recovery-orientation.

8. *“Recovery services are neither reimbursable nor evidence-based. First it was managed care, then it was evidence-based practice, and now it’s recovery. But recovery is neither cost-effective, nor evidence-based.”*

It may be argued that recovery is not a good use of health service monies if all that it achieves are social gains. But these social gains have significant health benefits. Evidence from personal testimonies suggests that feeling more ‘in control’ of one’s life and finding a meaning beyond illness have important health consequences. Recovery also means greater achievement of a range of social goals.

As to not being ‘evidence-based’, different kinds of evidence have different uses. Personal accounts have immediate validity, but controlled trial evidence, e.g. on the effectiveness of models for the communication of information about schizophrenia, approaches to the self-management of symptoms, effective help for families, effective approaches for placement in open employment, etc., already exists and may be used to support people in their recovery journeys.

9. *“Recovery approaches devalue the role of professional intervention. Why did I just spend ten years training if someone else with no training is going to make all the decisions?”*

No. Professional input remains important, but recovery places it in a different context. Professionals have expertise in effective treatment interventions, the functioning of groups, issues of engagement and conceptual frameworks to assist with the development of services and systems. It is therefore not about professionals stopping being ‘professional’ – it is often

not even about professionals employing *new* interventions – it is about *how* existing interventions are delivered and within what context.

10. *“Recovery increases providers’ exposure to risk and liability. If recovery is the person’s responsibility, then how come I get the blame when things go wrong?”*

Risk is inherent in all mental health services. In ‘recovery-oriented’ services risk may be increased, but it is sometimes necessary to take risks in order to learn and grow. We need to differentiate between risks that must be minimised (self-harm, harm to others) and risks that people have a right to experience. Recovery ideas encourage opportunities for growth and change (the ‘dignity of risk’) but in a responsible way.

Most risk is actually shared and everyone involved should be clear about what risks they are actually carrying. If an individual chooses to ignore clearly documented professional advice then they carry the risk. If a professional commits an act which clearly contradicts their ‘duty of care’, then they are responsible. Either way, the risk is not being appropriately managed. It is certainly not helpful if professionals think that they carry the sole responsibility for how people live their lives.

## What does recovery-oriented practice look like?

One of the biggest obstacles to the implementation of recovery-oriented practice has been the lack of clarity and agreement regarding what it really means in practice. How can we recognise a ‘recovery-oriented’ service? How will we know when we have made progress in achieving it? If we can succeed in creating recovery-oriented services, what kinds of benefits would there be for service users?

Attempts to define and measure recovery seem, almost inevitably, doomed to failure. The process is such a unique and personal journey that attempts to provide process and outcome ‘indicators’ seem at best presumptuous and at worst slightly offensive. However, there have been several attempts to develop measures of recovery-oriented practice (Campbell-Orde *et al.*, 2005; Tondora & Davidson, 2006) and work is ongoing to develop more (Andresen, Caputi & Oades, 2006).

Of course, mental health staff and mental health services cannot, in themselves, *practise* recovery – this can only be lived by service users and their families. But they can try to create the conditions in which individuals feel empowered and their sense of personal ‘agency’ can flourish. They can certainly try to avoid creating the kinds of conditions in which this is impossible.

We would argue that, despite the dangers of a ‘reductionist’ approach in this area, attempts to describe as clearly as we can the concepts underlying recovery and what they would mean in practice are important. Indeed, recent experience in this country suggests that without a degree of ‘operationalisation’, it is difficult to achieve meaningful service reform. Thus, the undoubted success of the mental health service reforms which have taken place over the last ten years (Appleby, 2007b) are largely due to the influence of clear models of service delivery, underpinned by very detailed ‘Policy Implementation Guides’ (PIGs). So, is there a need for a ‘Recovery PIG’? What might it look like?

Probably the best known attempt to measure recovery-oriented practice in this country is DREEM (‘Developing Recovery Enhancing Environments Measure’). This was originally produced by Priscilla Ridgeway and her colleagues in the United States (Ridgeway & Press, 2004) and edited for UK use by Piers Allott and Peter Higginson.

DREEM has been used to survey staff and service users’ views about recovery and the extent to which it is supported in particular services (Dinniss *et al.*, 2007). It is also beginning to be used as a service improvement tool to support the development of recovery-oriented practice across services over time (Gillespie, 2007).

DREEM seems a useful instrument. It provides a multi-faceted definition of recovery and recovery-oriented practice, with an attempt to identify outcomes from a service user’s point of view. Assessing the perspectives of service users and staff simultaneously means that they can be compared and the resulting discussion used to inform ongoing attempts to improve service quality.

However, it leaves open the crucial question of what kinds of *behaviour* staff need to display in order to create a recovery-oriented service. What kinds of training programmes are required to produce these behaviours and what kinds of

organisational factors are likely to contribute to – or impede – the uptake of these practices throughout the organisation?

## Staff skills and knowledge

One of the most interesting attempts to specify the key ingredients of recovery-oriented practice at a practitioner level is provided by Borg & Kristiansen (2004). They concluded that the key characteristics were:

- Openness
- Collaboration as equals
- A focus on the individual’s inner resources
- Reciprocity
- A willingness ‘to go the extra mile’.

They went on to suggest that these general skills must be combined with a high level of relationship skills – empathy, caring, acceptance, mutual affirmation, an encouragement of responsible risk-taking, and a positive expectation for the future. Perkins (2006) also puts ‘hope-inspiring relationships’ at the heart of her prescription for recovery-oriented practice.

Similar attempts to define the competencies and skills of recovery-oriented practitioners are to be found in O’Hagan (2001, cited in Roberts & Wolfson, 2004) and Glover (2002). Based on these ideas, it is possible to begin to specify the kinds of day-to-day interactions that one would expect to see occurring in recovery-oriented services. Box 3 sets these out in terms of ‘reflective practices’.

Box 3 provides the beginning of a set of standards which could, as suggested by Slade & Hayward (2007), be turned into a ‘fidelity scale’ for assessing the extent to which the day-to-day practice of professionals is truly ‘recovery-oriented’. It could also provide a person specification for staff recruitment and a structure for managers to feed back to staff on their performance. It is short enough to put up on a notice board, even (with a bit of editing) to have reprinted on a card to be carried by all employees in the service. It is not perfect, but it is a step towards providing a clear definition of recovery-oriented practice at the level of everyday interactions between individual staff and service users.

The challenge is then to translate these principles (or something like them) into a set of standards for team performance. Teams are now the key building blocks of mental health services and

### Box 3: 'Ten Top Tips' for recovery-oriented practice

After each interaction, the mental health professional should ask her / himself, did I...

- actively listen to help the person to make sense of their mental health problems?
- help the person identify and prioritise their personal goals for recovery – not professional goals?
- demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?
- identify examples from my own 'lived experience', or that of other service users, which inspires and validates their hopes?
- pay particular attention to the importance of goals which take the person out of the 'sick role' and enable them actively to contribute to the lives of others?
- identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of their goals?
- encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)?
- discuss what the person wants in terms of therapeutic interventions, e.g. psychological treatments, alternative therapies, joint crisis planning, etc., respecting their wishes wherever possible?
- behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to 'go the extra mile'?
- while accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations?

(after Shepherd, 2007)

– whether they are community mental health teams, crisis resolution, assertive outreach, or early intervention – they should aim to deliver their services using a recovery-oriented approach. Many teams are already trying to do this, but they need to be carefully monitored and continually reinforced by team leaders, using a clear set of standards. For example:

- Are there opportunities for service users to be employed in roles, including as direct care staff, within the teams?
- Does the team encourage real user involvement in decisions about treatment and management plans?
- Is the team leader committed to ensuring that staff show attitudes of respect and equality for service users (and their families) at all times?
- How does the leader ensure that this is happening?
- Does 'monitoring the quality of recovery-oriented practice of team members' appear on their job description and figure in their personal appraisal?

Setting these kinds of standards for teams and then ensuring that they happen are key tasks for the future.

The question of staff training then comes after the specification of practice. Useful work has been done on the training needs of staff (knowledge and skills) in the *Capabilities for Inclusive Practice* (National Social Inclusion Programme, 2007). This builds on the Ten Essential Shared Capabilities framework (NIMHE, 2004) which contains many recovery ideas. Each capability is developed in terms of its implications for an inclusive organisation / service and for an inclusive practitioner. There is also a separate capability of 'Promoting Recovery', but this is relatively brief.

*Capabilities for Inclusive Practice* is extremely comprehensive and is designed to inform commissioning and help services develop their capacity. However, it acknowledges that the guidance provided for individual practitioners will need to be integrated into day-to-day practice through the design of appropriate job roles and job descriptions and effective supervision.

The final goal is to incorporate all these ideas into organisational rules and procedures so as to create a 'culture' which promotes recovery-oriented practice. Guidance would help to tackle questions such as:

- Does it begin with a ‘Mission Statement’ and leadership ‘from the top’, or should it be built up from the bottom?
- What is the place of staff training?
- How – and by whom – should training be delivered?
- What is the importance of employing people with a service user background in the workforce?
- What should be the aims in terms of numbers of people with mental health problems in the workforce?
- What is the contribution of existing staff who have a ‘lived experience’ of mental health problems?
- How do we deal with stigma in recruitment and HR processes?

As well as focusing on the process of delivering recovery-oriented practice, we need also to look at the outcomes that we hope that these processes will deliver. From a service user perspective, the central outcome is simple: a satisfying and fulfilling life. As indicated earlier, this is probably best measured by some form of narrative account.

But for many service users it is not just a case of ‘feeling’ good, ‘feeling’ socially included, etc. They want to see objective evidence of increased participation in ordinary housing, paid employment, education and other ‘mainstream’ community activities. There are established ways of measuring such outcomes and new ones are being added with a specific recovery and social inclusion perspective (Huxley *et al.*, 2006). In our view these ‘objective’ measures are also important to include alongside evidence from personal accounts.

#### Box 4: Can organisations be ‘transformed’

Since 1999, one American mental health provider organisation has taken a radical approach to promoting recovery. META is a small (350 staff), ‘not-for-profit’ provider organisation located in Phoenix, Arizona (Ashcraft & Anthony, 2005).

In the spring of 1999, META staff, led by their chief executive, Gene Johnson, attended a national workshop where people with mental illness – including a distinguished psychiatrist – talked about how discouraging it was to feel continually discounted, disempowered and disrespected by the very service organisations that were supposed to be helping them. This struck an uncomfortable chord with Gene and his colleagues who decided they were that kind of organisation.

They therefore decided to embark on a process of ‘recovery’ for their organisation which has many parallels with the recovery process for individuals. One of the leading participants in that process, Lori Ashcraft, has identified some of the key steps:

- **A revision of the organisation’s goals and aims (the mission statement).**  
 This was transformed from being a statement about the organisation being ‘excellent’ to a statement about their responsibility to improve the lives of others.
- **A commitment to fully involving people with mental health problems in the running of the organisation at all levels in all roles.**

META began by recruiting to the management team a professional with ‘lived experience’ of mental health problems. This had a big impact and soon META was explicitly recruiting and training people with ‘lived experience’ to work alongside other professionals in their organisation. Currently more than 70% of META’s workforce are people with ‘lived experience’. Of these, 36% are in full-time employment and 64% part-time. This change in the ‘skill-mix’ has been key to transforming the culture of the organisation.

## An example from North America

- **A shift towards an ‘educational’ rather than a ‘therapeutic’ model.**

META quickly realised that if people with ‘lived experience’ were going to be able to function effectively as staff, many of them would need specific training. So, they developed a 70 hour, 5 week training programme for ‘peer specialists in recovery’.

A year after completing the training, 89% of one group was working: 29% in full-time employment, 52% part-time, and 19% hourly (Hutchinson *et al.*, 2006). In addition to the training of peer support specialists the ‘Recovery Education Centre’ also provides training for service users in recovery itself using ‘Wellness Recovery Action Plans’ – WRAP (Copeland, 2000).

The centre also provides courses in housing, employment and community living and trains local public [sector] mental health staff and staff from local independent sector agencies. Most of this training is delivered by trained and prepared ‘peer specialists’. This move towards an educational model was driven by an ideological belief in the value of an educational, rather than a ‘therapeutic’, model.

*“We wanted our Centre to be about reinforcing and developing people’s strengths, rather than adding to the attention placed on what was ‘wrong’ with them”*

(Ashcraft & Anthony, 2005, p.15).

The ‘Recovery Education Centre’ thus became the main engine for driving the organisation forwards. It has trained more than 500 peer specialists, both to work in META and in other mental health agencies across the US (and more recently also in Scotland and New Zealand). It provides a beacon of hope and a living demonstration that people with mental health problems can make a direct contribution to their own and others’ recovery by using their experience in paid staff positions.

- **The provision of a systematic system of support for ‘peer professionals’ employed in service delivery positions.**

META realised that if the peer support specialists were going to be able to sustain their contribution to mental health services, they would need ongoing support and supervision, just like any other professional group. This has now been achieved, both within META and in other organisations where peers are working. It is seen as vital in avoiding the loss of the unique contribution of peer specialists.

- **Growing in a flexible way, developing new operations, without losing core values and always meeting performance targets.**

Over the ten years in which META has grown, it has developed new services in the fields of crisis response, housing and employment but it has not lost its commitment to user involvement and recovery. It has consistently met its performance targets (reducing readmission rates, improving housing stability, reducing the use of physical restraints in the hospital, etc.) while competing in the very tough world of independent mental health sector providers in the US today.

**(For more information, visit [www.recoveryinnovations.org](http://www.recoveryinnovations.org))**

## Organisations 'in recovery'

*"I definitely want to work in something that I feel I'm contributing...I feel like I have a lot of untapped potential and if I can stay well I can make something of my life. I don't want not to achieve anything with my life..."*

Transforming services to take a recovery approach may therefore require a radical change in the way that they are currently organised. META (Box 4) is an example of an organisation 'in recovery' that has undergone a transformation which has been truly user-led.

In the example of META, the central importance of 'lived experience' has been a unifying force for the organisation, rather than a source of conflict. It has informed service design and organisational development and, since it is accepted that most of the workforce have 'lived experience' of mental health problems either in their own lives or those close to them, it has broken down the traditional barriers between 'staff' and 'users'. Both are respected for what they can bring, but the power of the organisation stems from its central focus on the needs of users, rather than the priorities of professionals. This has been a profound cultural change.

Many mental health services in this country seem a long way from this. Professional vested interests, a preoccupation with managing risk at the expense of learning, financial pressures, Foundation Trust applications, etc. have conspired to produce systems which seem to have lost contact with the clearly expressed needs of service users and their families (Healthcare Commission, 2007). The experience of META shows that these organisations could be transformed (and in only ten years!) but it does require vision, values, leadership – and a lot of hard work.

## Changing services by changing recruitment practices

For META, the transformation began with a fundamental change to recruitment practices. We do have a commitment to employing people with mental health problems in mental health services in this country (Department of Health, 2002) and there is plenty of useful guidance (e.g. Seebohm & Grove, 2006). The 'STR' initiative ('Support, Time Recovery' workers, Department of Health, 2003) has also been very valuable, but we have a long way to go to emulate the achievements of organisations like META.

A good example of employing people with mental health problems in the workforce of an NHS trust is South West London and St George's ([www.swlstg-tr.nhs.uk](http://www.swlstg-tr.nhs.uk)). The trust established a 'User Employment Programme' in 1995 which was designed to increase access to ordinary jobs within mental health services for people who have themselves experienced mental health problems. Between 1995 and 2007, 142 people were supported in 163 posts within the trust and on the 1st January 2007, 86% of these people continued to work within or outside the organisation or were engaged in professional training (Perkins, Rinaldi & Hardisty, 2008, forthcoming).

In addition, in every year between 1999 and 2006, at least 15% of new recruits within the trust had themselves experienced mental health problems and more detailed analysis of 2005/6 recruitment data shows that new recruits with mental health problems were more numerous among those recruited to higher grade positions.

These are very encouraging developments, but South West London & St. George's remains the exception rather than the rule. Until we begin to think more radically about how to reshape the mental health workforce, then it is almost inevitable that the culture of organisations will remain professionally focused.

## Concluding remarks

*“It seems hard to disagree with the proposition that recovery should be the guiding purpose for future mental health services. For what are we and our services doing if we are not supporting individuals and their families in a process of personal recovery? It is equally clear that by no means everyone is comfortable with embracing the ‘recovery agenda’, and professionals, service users and carers alike have expressed reservations that need to be carefully considered.”* (Roberts & Hollins, 2007, p.397)

Recovery is an important, new idea which has radical implications for the design and operation of mental health services. There are clearly obstacles to its implementation. To help to overcome them, there might be a value in thinking about a recovery-oriented ‘Policy Implementation Guide’ to provide simple guidelines for practice at an individual, team and service level.

Such a ‘Recovery PIG’ could be used as a developmental tool, auditing local practice against agreed standards and moving the service forward to a more recovery-focused orientation using a repeated audit cycle. This is very similar to an ‘action research’ paradigm, which has been shown to be one of the most effective ways of achieving major organisational change (Iles & Sutherland, 2001).

A more radical way of transforming mental health services may be to change recruitment practices so as to involve many more people with ‘lived experience’ as paid staff, including as managers and practitioners.

Either way, achieving ‘recovery-oriented practice’ will mean a significant change in the *culture*, as well as to the *organisation*, of services. It means the whole organisation accepting the reality that ‘mental illness’ is all around us and that people with ‘mental health problems’ are already involved in delivering mental health services: it’s just that they are encouraged to keep this identity secret.

All this means some radical changes to traditional power relationships and, possibly, to traditional recruitment practices. This is for the future. In the meantime, we hope that this paper will help to galvanise a national commitment to making recovery-oriented practice the norm in all UK mental health services.

This paper marks the beginning of work at the Sainsbury Centre to refine this vision and define the steps that need to follow. We look forward to working with others to support the changes that will make recovery a reality for all.

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## Making Recovery a Reality

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