



# The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part Two: a review of the grey literature including book chapters and policy documents

T. STICKLEY<sup>1</sup> PHD MA Dip N Dip Couns PGCHE RMN &  
N. WRIGHT<sup>2</sup> PHD MA BN RN

<sup>1</sup>Associate Professor, School of Nursing, Midwifery & Physiotherapy, University of Nottingham, and <sup>2</sup>Research Fellow, Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Nottinghamshire, Derbyshire and Lincolnshire, Nottingham, UK

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*Correspondence:*

T. Stickley

School of Nursing, Midwifery &  
Physiotherapy

University of Nottingham

Duncan MacMillan House

Porchester Road

Nottingham NG3 6AA

UK

E-mail: [theo.stickley@nottingham.ac.uk](mailto:theo.stickley@nottingham.ac.uk)

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## Accessible summary

- The majority of articles that have been published about recovery and mental health have been published within the 4 years preceding this literature review. However, there are very articles that review the recovery literature. This article examines the non peer-reviewed or grey literature.
- Themes from the non-peer-reviewed literature include: a social, historical and political critique; a philosophy of hope for the individual; individual identity and narrative and models and guidance for mental health practice.
- The findings from the study have important implications for clinical practice. To promote recovery in mental health, practitioners need to foster an ‘atmosphere of hope’. This indicates there needs to be shift away from the traditional dominance of the medical model and coercive treatment strategies towards more patient centred care. However, this is difficult to achieve in a statutory care system geared towards risk elimination and containment. In any health care system where ‘forced’ treatment is an option, it is difficult for practitioners to develop relationships which are wholly recovery orientated.
- The necessity for therapeutic relations is a strong component of this study.

## Abstract

This paper is the second in a series of two which reviews the current UK evidence base for recovery in mental health. As outlined in the previous paper, over the last 4 years a vast amount has written about recovery in mental health (approximately 60% of all articles). Whereas the first review focused on the peer-reviewed evidence; this paper specifically focuses on the grey/non-peer-reviewed literature. In total, our search strategy yielded the following: 3 books, a further 11 book chapters, 12 papers, 6 policy documents and 3 publications from voluntary sector organizations. Each group of publications was analysed for content, and they are discursively presented by publication group. The findings are then presented as themes in the discussion section. The themes are: social, historical and political critique; philosophy of hope for the individual; individual identity and narrative; models and guidance for mental health practice. We conclude that there is a need for both empirical research into recovery and a clearer theoretical exposition of the concept.

## Introduction

This is the second of two literature reviews related to recovery in mental health. The first paper synthesized the contemporary peer-reviewed evidence-base. By contemporary we are referring to papers published during the 4 years 2006–2009 (inclusive) and five themes emerged from our analysis: hope and optimism, meaning to life, activities promoting recovery, definitions and discourses and implications for mental health practice. In this second article we examine the grey literature including non-peer-reviewed articles, books, book chapters and policy documents published during the same period. We also compare and contrast the findings from both the peer-review and the grey literature to draw an informed conclusion on the subject of recovery in the UK and the nature of the underpinning evidence-base.

## Aim

As stated in the previous paper, the aim of the review was to analyse the contemporary British literature related to recovery in mental health. In this paper we discuss the second phase of the review, which focused on the non-peer-reviewed or grey literature.

## Method

### Search strategy

To identify relevant literature for this phase of the review, three separate searches were conducted. First, the database

search for journal articles as described in the previous paper. In brief, this strategy used the term ‘recovery’ in the title field and mental health in the subject or keyword in eight electronic indexes (ASSIA, British Nursing Index, CINAHL, EMBASE, MEDLINE, PSYCHINFO, Web of Science and Web of Knowledge). Once the limits were imposed as described in Part One, this strategy yielded 23 papers overall, 11 of which are non-peer-reviewed articles, which fit the inclusion criteria of examining recovery in mental health and being a UK-focused paper. These are listed in Box A.

Second, relevant books and book chapters were found using the University of Nottingham electronic library searching system, and the Internet book-seller web site Amazon was searched. To be included books needed to be British, published from 2006–2009 (inclusive) and were either devoted to mental health recovery or had chapter titles containing the word ‘recovery’. Only three British books were found that had recovery in the title and were related to mental health (Watkins 2007, Hall *et al.* 2008, Slade 2009). However, the keywords ‘mental health’ contained in book titles yielded 380 results. Once books published overseas and specialist books unrelated to general mental health practice were eliminated, 71 books remained and these were inspected to see if they had at least one chapter devoted to recovery. Of those, 15 met this final criterion. References for each of these books and book chapters can be found in Box B.

Finally, government policy documents relating to mental health recovery were accessed from the Department of Health web site. Non-statutory documents were identified from the following web sites: Mind ([### Box A](http://</a></p></div><div data-bbox=)

#### Non-peer-reviewed articles

- Blank A. & Hayward M. (2009) The role of work in recovery. *British Journal of Occupational Therapy* 72, 324–326
- Craig T. (2008) Recovery; Say what you mean and mean what you say. *Journal of Mental Health* 17, 125–128
- Faulkner A. (2007) The recovery bandwagon will need to travel slowly and carefully if it is to take everyone with it. *Mental Health Today* October 2007, 26
- Gillespie M. & Clarke A. (2009) Recovery group for people with severe and enduring mental health problems. *Clinical Psychology Forum* 172, 15–18
- Lester H. & Gask L. (2006) Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery? *British Journal of Psychiatry* 188, 401–402
- O’Hagan M. (2008) Recovery: the true meaning of recovery. *Mental Health Today* December 2008, 16–17
- Petch A. (2008) Mental health recovery. *Community Care* 1708, 32–33
- Ramsey C. & Till U. (2009) A long and emotional story from illness to recovery. *Mental Health Practice* 12, 30–34
- Repper J. (2006) Viewpoint: discovery is the new recovery. *Mental Health Today* February 2006, 37
- Schrank B. & Slade M. (2007) Recovery in psychiatry. *Psychiatric Bulletin* 31, 321–325
- Stowers C., Blacker R., Elliott S., *et al.* (2009) Recovery of what by whom? *Clinical Psychology Forum* 196, 50–53

**Box B**

References for books and book chapters published between 2006–2009 focusing upon recovery

- Buchanan-Barker P. (2009) Reclamation beyond recover. In: *Psychiatric and Mental Health Nursing: The Craft of Caring*, 2nd edn (ed Barker, P.), pp. 681–689. Hodder Arnold, London
- Campbell J., Stickley T. & Bonney S. (2008) Recovery as a framework for care planning. In: *Care Planning in Mental Health: Promoting Recovery* (eds Hall, A., Kirby, S.D. & Wren, M.M.), pp 113–135. Blackwell Publishing, Oxford
- Copperman J. & Hill F. (2006) Women's mental health and recovery. In: *Mental Health Today: A Handbook* (eds Jackson, C. & Hill, K.), pp. 445–455. Pavilion Publishing, Brighton
- Dean F.P. & Crowe T.P. (2007) Building and maintaining a recovery focused therapeutic relationship. In: *Handbook of Psychosocial Rehabilitation* (eds King, R. Lloyd, C. & Meehan, T.), pp 57–70. Blackwell Publishing, Oxford
- Deegan P. (2009) Recovery: the lived experience of rehabilitation. In: *Mental Health Still Matters* (eds Reynolds, J. Muston, R. Heller, T., *et al.*), pp. 58–65. Palgrave Macmillan, Basingstoke
- Hall A., Wren M. & Kirby S. (2008) *Care Planning in Mental Health: Promoting Recovery*. Blackwell Publishing, Oxford
- Hingley D.A. (2009) Recovery. In: *Introduction to Mental Health Nursing* (ed Wrycraft, N.), pp. 197–206. Open University Press, Maidenhead
- Repper J. & Perkins R. (2009a) Recovery and social inclusion. In: *Mental Health Nursing Skills* (eds Callaghan, P., Playle, J. & Cooper, L.), pp. 85–95. Oxford University Press, Oxford
- Repper J. & Perkins R. (2009b) Recovery and social inclusion. In: *The Art and Science of Mental Health Nursing: A Textbook of Principles and Practice*, 2nd edn (eds Norman, I. & Ryrie, I.), pp. 86–112. Open University, Maidenhead
- Roberts G. & Wolfson P. (2006) New directions in rehabilitation: learning from the recovery movement. In: *Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry* (eds Roberts, G., Davenport, S., Holloway, F., *et al.*), pp. 18–37. Gaskell, London
- Slade M. (2009) *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge University Press, Cambridge
- Watkins P.N. (2007) *Recovery: A Guide for Mental Health Practitioners*. Churchill Livingstone Elsevier, Edinburgh
- Williams A. (2009) The recovery of hope. In: *Mental Health Still Matters* (eds Reynolds, J., Muston, R., Heller, T., *et al.*), pp. 218–220. Palgrave Macmillan, Basingstoke
- Whitehill I. (2009) Recover: a personal perspective. In: *Psychiatric and Mental Health Nursing: The Craft of Caring*, 2nd edn (ed Barker, P.), pp 51–57. Hodder Arnold, London

www.mind.org.uk), Mental Health Foundation (<http://www.mentalhealth.org.uk>), Sainsbury Centre for Mental Health (<http://www.scmh.org.uk>) and Rethink (<http://www.rethink.org.uk>). A list of these publications can be found in Box C: Statutory and non-statutory policy documents.

### Findings from books 2006–2009

Books and book chapters devoted to recovery were largely authored by mental health professionals with contributions from people who identified themselves as users of mental health services. One chapter (Ramon *et al.* 2009) was excluded as the contents were reprinted from an earlier article included in Part One of our review. The content of the remaining 14 books and individual chapters are presented in this section of the review.

Although Hall *et al.* (2008) has recovery in its title, there is only one chapter wholly devoted to the subject. This is

authored by Campbell *et al.* (2008). For them, recovery is a worthwhile concept but it is regarded as a social construct and as such has the potential to become a product malleable to professional and statutory forces. Barker (2009) includes three chapters with recovery in the title, although one was excluded because the author was from New Zealand. The first is authored biographically by Whitehill (2009) who describes her recovery as a 'life long quest'. She emphasizes the positive role of psychotherapy and lists factors that have helped in her recovery process. By way of contrast, she also cites the factors that have blocked her processes. She gives clear instructions for mental health nurses seeking to help promote recovery; human acceptance with professional understanding is called for and translated into practical applications. Whitehill calls for a paradigm shift from 'containment' to 'therapeutic experience'. The second included chapter is written by Buchanan-Barker (2009), who was co-author with Barker of the previously published *The Tidal Model: A*

### Box C

Statutory and non-statutory policy documents

Chief Nursing Officer (2006) *From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing*. Department of Health, London

Care Services Improvement Partnership, Royal College of Psychiatrists & Social Care Institute for Excellence. (2007) *A Common Purpose: Recovery in Future Mental Health Services*. Social Care Institute for Excellence, London

Department of Health (2009) New horizons. Available at: <http://www.dh.gov.uk/en/Healthcare/Mentalhealth/NewHorizons/index.htm>

Mental Health Foundation (2007) Recovery. Available at: <http://www.mentalhealth.org.uk/information/mental-health-a-z/recovery/#tools>

Mind (2008) *Life and Times of a Supermodel. The Recovery Paradigm for Mental Health. MindThink Report 3*. Mind, London

Nursing and Midwifery Council (2010) Mental health nurses. Available at: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=4076>

Rethink (2005) *A Report on the Work of the Recovery Learning Sites and Other Recovery-Orientated Activities and Its Incorporation into the Rethink Plan 2004–08*. Rethink, London

Rethink (2009) A brief introduction to the recovery approach. Available at: [http://www.rethink.org/living\\_with\\_mental\\_illness/recovery\\_and\\_self\\_management/recovery/index.html](http://www.rethink.org/living_with_mental_illness/recovery_and_self_management/recovery/index.html)

Shepherd G., Boardman J. & Slade M. (2003) *Making Recovery a Reality*. Sainsbury Centre for Mental Health, London

*Guide for Mental Health Professionals'* (Barker & Buchanan-Barker 2004). The chapter offers a précis of this work and reinforces the Tidal Model as a model for recovery.

In his chapter entitled 'Recovery', Hingley (2009) offers a simplistic introduction to the concept and bases his description largely on the earlier work of Repper & Perkins (2003). He attempts (albeit unconvincingly) to explain recovery as a postmodern phenomenon and refers to a 'recovery model' (p. 205) as if one cogent model exists. Repper & Perkins (2009a,b) have published two separate chapters, both called '*Recovery and social inclusion*' (a reverse of their 2003 book title '*Social Inclusion and Recovery*'), one in Norman & Ryrle (2009) and the other in Callaghan *et al.* (2009). In these chapters they summarize key points from their original model, which was probably the first British publication to explicate recovery and to also strongly associate the concept with social inclusion. The chapters update their work by relating to contemporary policy and practice and offer methods for practitioners to promote recovery and social inclusion for client work. The second edition of '*Mental Health Matters*' (Reynolds *et al.* 2009) includes three chapters with recovery in the title. The first of these has been excluded from our study (Deegan 2009) as this chapter is an edited version of a 1994 publication. The second (Williams 2009) is a biographical account from a service user's perspective and she describes how she has worked collaboratively with statutory workers to facilitate her own recovery and restore a sense of hope.

Roberts & Wolfson (2006) regard the development of the recovery movement as a collaborative initiative among those who seek improvement in mental health services. In terms of definition, they broadly follow the two general interpretations of recovery that of first, the medical definition of absence of symptoms (clinical recovery) and second, the developmental model that views people on a journey (in process) to recovery (personal recovery). They compare the differences that underpin both the medical model and the 'recovery model' and highlight the contrasts in philosophy. They therefore speculate the potential difficulties in turning a medically driven service into one that is more in tune with recovery principles and one that promotes self-management. They observe that implementation of a recovery philosophy is not potentially just at odds with attitudes in psychiatry, but the National Health Service *per se*, especially in relation to risk.

In Jackson & Hill (2006) Copperman & Hill (2006) focus upon women and recovery. They remind the reader of social inequalities that extend to mental health services where women have been disadvantaged. Their response is to give voice to some women in their study and apply recovery approaches to the mental health needs of women focusing on a strengths-based philosophy and the need for therapeutic risk taking, especially with self-harming behaviour. In King *et al.* (2007), Dean & Crowe (2007) attribute recovery largely to the quality of the therapeutic alliance. This is conceptualized within a Rogerian framework (Rogers 1951) and therefore grounds recovery principles in existing humanistic literature. They assert that what mental

health workers need to do to promote recovery is not necessarily to develop new approaches but learn from what has worked in the past.

Watkins (2007) focuses the entire book on recovery. The book is written by a mental health nurse but includes contributions from people who have experienced mental distress. Similar to previous works on recovery (Coleman 2004 and Barker & Buchanan-Barker 2004), Watkins rejects the medical model of mental distress and conceptualizes recovery as attainable in spite of psychiatry not because of it. Recovery is facilitated by workers who understand the human condition and that can demonstrate human qualities that enable people to grow and heal. Watkins' thesis is also grounded in humanistic principles.

Slade (2009) aims his book: *'Personal Recovery and Mental Illness'* at mental health professionals and intends to apply the principles of recovery into a guide for mental health practice. The well-rehearsed basic principles of recovery are presented and Slade gives a convincing rationale for recovery values to underpin mental health practice. He advocates shifting away from traditional approaches such as preventing relapse and managing risk, towards more humanistic, person-centred approaches informed by the recovery literature and policy, such as supporting people towards establishing their own goals based upon aspiration and hope. Slade also introduces his *Personal Recovery Framework*, which is based upon the person's need for a positive identity having experienced the personal and social losses associated with mental health problems.

### British policy on recovery 2006–2009

The three key policy documents informing UK service development appear to be: *'Making Recovery a Reality'* from the Sainsbury Centre for Mental Health (Shepherd *et al.* 2008); *'A Common Purpose: Recovery in Future Mental Health Services'* [Care Services Improvement Partnership (CSIP) *et al.* 2007]; and *'New Horizons'* [Department of Health (DH) 2009]. The first two introduce the concept of recovery and its appropriateness for implementation in mental health practice and the last one embodies these principles in its language throughout its strategy framework.

*'New Horizons'* (DH 2009) employs the language of recovery. For example, it recognizes that people should be in control of their own lives and the strategy emphasizes the significance of hope to people's lives. However, the discourse uses such principles to strengthen the current political agenda towards direct payments and personalized budgets rather than emphasizing humanistic approaches.

The Sainsbury Centre policy document, *'Making Recovery a Reality'* (Shepherd *et al.* 2008), offers 10 principles for recovery (Box D) that are based upon the recovery

literature, and includes self-management; however, there is no explicit reference to move towards personalized budgets and direct payments. Again the policy embodies the recovery principles based upon the relevant literature and is optimistic that if the principles are adopted by statutory services, a 'radical transformation' will take place to how mental health services are delivered in the future. Because the document is not a government publication, it appears to have the freedom to acknowledge the danger of using recovery principles to force people into inappropriate work in order to reduce the cost of state benefits.

In *'A Common Purpose: Recovery in Future Mental Health Services'* (CSIP *et al.* 2007), support for a recovery approach to mental health service delivery is wholly endorsed. The joint position paper is more pragmatic than the Sainsbury Centre for Mental Health paper as it explores the potential obstacles for implementing recovery approaches and acknowledges the complexities in attempting to measure recovery through longitudinal research methods and therefore asserts that the evidence-base supporting the approach is limited.

### Voluntary sector publications on recovery 2006–2009

Mind (2008) is a report from a *'roundtable discussion'* conducted in 2007 between 23 mental health *'experts, stakeholders and opinion formers'* to examine and debate the notion of recovery in UK policy. The result is a frank and significant document identifying key contemporary issues surrounding the topic with a number of critical points not fully explicated elsewhere. For example:

The horizons of recovery have been circumscribed by poor mental health services, excessive use of compulsion, lack of service user involvement, lack of choice of treatments, social exclusion, stigma and discrimination. (p. 5)

The report offers a critical perspective regarding institutional and societal racism:

A lot of services that claim to work within the recovery approach – and for which independent living is an important step – fail to engage with factors that hinder recovery, including the experience of racism (Jayasree Kalathil). (p. 6)

The report includes a lengthy discussion regarding the political motivation for recovery that might mean getting people into work inappropriately and reducing welfare costs:

The biggest concern about the political adventures of the recovery concept was its association with what were perceived to be regressive changes to the welfare system and a narrow focus on employment as the holy grail of recovery. (p. 11)

#### Box D

##### The 10 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 emphasizes 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.

(Shepherd *et al.* 2008)

The Mental Health Foundation (2007) does not appear to have one single policy devoted to recovery although, there is a webpage given over to the topic. The definition offered is one that depicts recovery as a subjective and humanistic experience involving self-discovery and personal growth. They regard public attitudes to mental illness imposing limits on people's potential and the 'recovery model' helps people achieve their own goals and aspirations. The Mental Health Foundation (2007) draws a strong link between recovery and social inclusion. Furthermore, there is a call for services to support the inclusion of service users towards mainstream activities and opportunities; access to social, educational and employment opportunities are emphasized.

Both the Mental Health Foundation (2007) and Rethink (2009) advocate the American Wellness Recovery Action Planning model (Copeland 2009). Rethink previously published their '*Recovery Report*' in 2005 (Rethink 2005). The organization rejects the medical definition of recovery and leans heavily on overseas models and definitions and has influenced their self-management project, encouraging people to take responsibility for their own recovery.

Both the Chief Nursing Officer (CNO 2006) and the Nursing and Midwifery Council (NMC 2010) have recognized the significance of recovery for mental health nurse practice. The CNO report on mental health nursing wholly

embraces a recovery approach: '*Mental health nursing should incorporate the broad principles of the Recovery Approach into every aspect of their practice.*' (CNO 2006, p. 4). The CNO report also recognizes the importance for nurses to be supported by their employers to deliver care based on recovery principles. For the NMC, recovery is regarded as a method for the modernization of mental health services. Significantly for mental health nurses, the person's expertise is recognized over and above the expertise of the nurse. An emphasis is placed upon person-centred care and positive risk taking.

#### Non-peer-reviewed journal articles

Eleven non-peer-reviewed articles were found relating to recovery in mental health in the UK. Of these one (Petch 2008) described an empirical study, two (Gilespie & Clarke 2009, Stowers *et al* 2009) outlined the establishment of therapeutic groups based on recovery principles, three were editorial articles (Lester & Gask 2006, Schrank & Slade 2007, Craig 2008), four were opinion articles (Repper 2006, Faulkner 2007, O'Hagan 2008, Blank & Hayward 2009) and one was a personal narrative of an individual's recovery experiences (Ramsey & Till 2009).

Hope and optimism and definitions and discourses were highlighted in the peer-reviewed literature as key themes.

This is also the case for the papers considered here. Petch (2008) highlights that for recovery to proceed, people need to believe in themselves, develop a positive identity and have a knowledge that recovery is possible. External factors that could enhance this process were also reported, for example, a supportive family and having life choices accepted and validated. Lester & Gask (2006) also highlight the importance of services having an 'atmosphere' of hope and optimism and Craig (2008) supports this by arguing that it is the way mental health services are provided rather than what is provided, which makes them hopeful and able to promote recovery. Mental health practitioners have a key role in 'carrying hope' for service users when they are not able to do it for themselves (Ramsey & Till 2009).

How recovery is implemented into practice and the ability of services to be hopeful and optimistic is dependent on how it is defined and the dominant discourses around it. This was also identified in the peer-reviewed literature review. However, within the 11 non-peer-reviewed articles it is clear that this is given a more critical edge. Craig (2008), for example, argues that the concept of recovery needs to be widened to incorporate the retention and development of improved functioning and raises two questions: how do we safeguard against recovery being used to justify cuts in service provision and how is it possible to promote individual self-determination with the obligation to run safe services? Similarly, Lester & Gask (2006) question what the definition of recovery is and whether it is compatible with chronic disease management models. They highlight that within health policy some documents emphasize chronicity whereas others focus on recovery. These differing discourses lead to problems for the design and implementation of coherent mental health services (Lester & Gask 2006). At a professional level Schrank & Slade (2007) argue that if recovery really is to be embedded into service provision a shift in the philosophy that underpins current practice and also the values and attitudes of staff need to occur. It is suggested that this may not be easy as power may need to be transferred to service users (Schrank & Slade 2007). How far the practitioner and service user discourse around recovery converge and diverge was also highlighted by Repper (2006). Here it is argued that practitioner definitions of recovery do not match the service user experience, which would be more accurately described as a personal journey of 'discovery' (Repper 2006). Faulkner (2007) takes this argument a step further by suggesting that for recovery to be central to care provision it is not just within the context of mental health services that change needs to take place but in society as a whole. Indeed, O'Hagan (2008) argues

that both service users and their communities need to believe that they hold most of the solutions to the difficulties caused by mental health problems.

How recovery is defined and articulated has an influence on practice and the development of interventions to promote it. Gilespeie & Clarke (2009) and Stowers *et al.* (2009) described the use of therapeutic/self-management groups based on recovery principles for people with severe and enduring mental health problems. They used some quantitative measures to record individual's progress in the group (suggesting that recovery is linked to a reduction or amelioration of the symptoms of mental illness) but the qualitative accounts indicate that the group forum allowed the sharing of experiences and social support as beneficial to participants. Blank & Hayward (2009) question how the definition of recovery for an individual can be translated into a need for occupation and they highlight the role of employment in supporting recovery and facilitating social inclusion. These 'interventions' again raise the issues discussed by Craig (2008) and Repper (2006): is recovery a personal journey and experience or is it associated with improved functioning and measurable outcomes such as returning to work? To further the theoretical discussion of recovery as a concept it may need to consider whether it is possible for one concept to encompass both dimensions.

## Discussion

Unlike the peer-reviewed literature; the evidence that comprises the 'grey' or non-peer-reviewed evidence is an eclectic mix of books, book chapters, policies and journal articles. However, when we implemented the thematic analysis of the body of literature, it became apparent that there was much commonality between the various sources. The Mind (2008) report stands out as the one document that offers a critical perspective. The findings from all of these documents have been presented separately and in a discursive manner, we now discuss the collective findings from these documents around four core themes. These themes were determined by a rigorous content analysis through iterative reading and discussion between the researchers. The themes are not mutually exclusive and are as follows:

1. Social, historical and political critique.
2. Philosophy of hope for the individual.
3. Individual identity and narrative.
4. Models and guidance for mental health practice.

By combining the findings from the varied literature it is hoped that a coherent and consistent message can be presented from the non-peer-reviewed evidence, which can be concluded and compared with Part One of the review. By doing this the current context for recovery in mental health

can be ascertained and the theoretical and empirical underpinnings illuminated.

### Historical, social and political critique

In discussions of the development of the recovery concept, a historical perspective is often included (Watkins 2007, Campbell *et al.* 2008, Buchanan-Barker 2009). The recovery concept is directly related to how people experiencing mental distress have been treated in the past and are being treated in the present by the societies in which they live. The relationships therefore between people and those who provide services are central to the recovery paradigm; either as those who receive services (Ramsey & Till 2009, Whitehill 2009), or those who provide (Shepherd *et al.* 2008). While the recovery movement may have its roots in the asylum closure programme (Warner 2004), the current literature that promotes recovery also endorses the theme of promoting social inclusion. As the period of time widens since the programme of asylum closure, issues regarding social integration remain. While the desire for social inclusion may be considered one of social justice (Repper & Perkins 2009a,b), the political emphasis upon people accessing employment with the implementation of the personalization agenda (DH 2009) has meant that social inclusion has also become synonymous with getting people off the benefits system and cost-cutting (Craig 2008, Mind 2008). Furthermore, there are powerful social forces at work that may militate against recovery (Copperman & Hill 2006, Campbell *et al.* 2008). In the UK, the burgeoning recovery agenda has been in the context of the 13-year-long New Labour era that has since come to an end. Only time will tell whether a commitment to recovery as a policy agenda and social inclusion as a concept will survive the political upheaval.

### Philosophy of hope for the individual

The presence and need for hope has been central to the recovery paradigm and the ability to hope has become central to what might be considered the philosophy of recovery (Lester & Gask 2006, Craig 2008, Petch 2008, DH 2009, Ramsey & Till 2009, Slade 2009, Williams 2009). In this review, the ability to find hope and for mental health workers to provide hope-inspiring relationships, has been located within a humanistic theoretical framework (Barker & Buchanan-Barker 2004, Dean & Crowe 2007, Watkins 2007, Slade 2009, Whitehill 2009). How the existence of hope might contribute towards a positive identity has been acknowledged (Petch 2008). In Goffman's (1963) theory of 'spoiled identities', people's identities become spoiled by society. While people may have to cope with

experiencing mental health problems, these may be more manageable than the subsequent effects of stigmatization and discrimination. Thus by engendering a sense of hope, a more positive identity might be developed and a psychological answer is developed to counter a socially constructed problem. Historically, psychiatric service provision has incorporated a fairly hopeless message (the need to take medication indefinitely, the impact of illness both socially and personally and so on). Contemporary recovery literature acknowledges this and the enormous task of changing services to become more hopeful (Lester & Gask 2006). As well as policy frameworks, there is a need for individual mental health practitioners to engender hope (Ramsey & Till 2009). In a system, however, where the medical model dominates, a philosophy of hope may be extremely difficult to implement as the recovery philosophy remains at odds with the dominant discourse (Roberts & Wolfson 2006).

### Individual identity and narrative

Recovery in mental health is steeped in individual stories, narrative and as highlighted above is closely tied to issues of identity. It has been highlighted that recovery is a highly personal experience, which can be both helped and hindered by the actions of others (Whitehill 2009). Others in this context may be mental health professionals. As Repper (2006) identifies often the service user and professional discourse do not correlate, and it is also often the case that neither do local community and society discourses (O'Hagan 2008). How an individual constructs their identity and personal narrative of recovery from mental illness is very much defined by the actions and support of others. The Mental Health Foundation (2007) states that public attitudes towards mental health and illness can impose limits on the potential to achieve recovery. Wider support for recovery is also documented with the CNO review (CNO 2006), which suggests that mental health nurses need to be supported by their employers to work in a recovery-orientated way. It would therefore be apparent that for recovery to become embedded and recognized as important, wider support from mental health service providers and society as a whole is needed. Whether this is possible in the current policy context of inconsistent messages (for example, recovery versus control) remains to be seen (Lester & Gask 2006). In this debate the NHS employs the rhetoric of humanistic philosophy (articulated in concepts such as compassionate or patient-centred care); however, the practicalities of providing mental health services involve more control than this standpoint can encompass. The language of recovery may have made its way into policy discourses (the '*New Horizons*' document uses the word recovery repeatedly) but the extent that this is cogent

with individual experience and narrative remains open for discussion.

The papers that discussed the use of therapeutic groups (Gilespie & Clarke 2009 and Stowers *et al.* 2009) indicate that there is a desire to assist individuals to achieve recovery. However, while activity can be beneficial in promoting recovery, as highlighted in the first part of this review, without the right atmosphere and philosophy underpinning them they may prove fruitless. As Craig (2008) identified it is the way services are provided rather than the techniques they employ, which are beneficial. Indeed, it needs to be questioned whether it is the interventions that recovery groups offer which lead to change or the opportunity to gain peer support and listen to others' narratives which is inspiring.

### Models and guidance for mental health practice

It is clear from this exploration of the recovery concept that the individual stories and experiences from those that use mental health services have become widely endorsed by mental health practitioners and policy makers. Recovery as a model of mental health care appears to be in the ascendancy at the current time. However, as highlighted above the contradictions between and within policy documents may mean the service user narrative becomes lost or 'diluted' within the rhetoric of professional practice and policy. For example 'New Horizons' (DH 2009) emphasizes improved human rights for people who experience mental distress, especially in relation to improved access to education or employment. However, it is understandable that some may perceive this as a way to reduce state benefit payments as previously observed by Mind (2008) and Shepherd *et al.* (2008).

The degree that recovery can be seen as a model for practice is questioned within the evidence-base. While some authors such as Hingley (2009) refer to a 'recovery model' the individual nature and narrative of recovery appears to be at odds with this. It may be more helpful for mental health practice and future service provision to see recovery as a broad set of principles, which can underpin person-centred and holistic ways of working. The CNO report (CNO 2006) is one example of this. Here, recovery is articulated as an overarching approach, which should be embraced by mental health nursing.

The integration of recovery into policy and guidelines for mental health practice provides a direction for where future mental health services should go. It ensures that a set of minimum standards are met. Policy cannot however, lead to innovative and novel approaches to practice or ensure that therapies are given in a way, which fosters hope and optimism as this is dependent on those providing care

being able to deliver it in a way, which engages with and listens to the individual narratives of those experiencing mental distress. Both parts of this review have highlighted this point, promoting recovery is not perceived to be a set of techniques or therapies to be mandated but an atmosphere and way of being with another person (Craig 2008, Ramsey & Till 2009).

### Implications for practice

Literature from non-peer-reviewed sources has important implications for clinical practice. The texts reviewed indicate that to promote recovery in mental health, practitioners need to foster an 'atmosphere of hope' (Lester & Gask 2006). This indicates there needs to be shift away from the traditional dominance of the medical model and coercive treatment strategies towards more patient-centred care (Schrank & Slade 2007, Watkins 2007). However, this is difficult to achieve in a statutory care system geared towards risk elimination and containment. As Lester & Gask (2006) identify within current practice there is a contradiction between recovery and control. In any health-care system where 'forced' treatment is an option, it is difficult for practitioners to develop relationships, which are wholly recovery-orientated.

The necessity for therapeutic relations is a strong component of this study (Dean & Crowe 2007, King *et al.* 2007, Watkins 2007, Slade 2009, Whitehill 2009). The professional-client relationship is significant especially as the worker may instil a sense of hope within the individual. In this context, talking treatments are also valued (Whitehill 2009). Collaborative working between workers and clients is regarded as essential to recovery (Roberts & Wolfson 2006, Williams 2009). Some of the grey literature included individual narratives, which are also regarded as significant in the recovery paradigm. Narratives help to strengthen a sense of identity imperative for recovery (Petch 2008, Slade 2009). The need to promote social inclusion, especially engagement with education, work and leisure is strongly advocated (DH 2009, Repper & Perkins 2009a,b). The use of models has been questioned in this review (Mind 2008); while some models provide useful frameworks for implementing practice, models themselves cannot provide care; only a practice based upon a meaningful philosophy can make a difference to a person's life.

### Conclusion

Recovery is a complicated and multifaceted concept with no universal definition. It spans individual, professional and policy domains. Developing originally from service

user experiences of mental distress, the term recovery has now become commonplace in both professional and policy discourses. While a move towards a recovery orientation is broadly welcomed the implications of this for what it means and how it is interpreted is complex. There is a danger that the original meaning of recovery becomes 'filtered' through the different lenses applied to it. The grey or non-peer-reviewed literature demonstrates the importance of humanistic philosophy to recovery and how the values and attitudes of professionals influence the atmosphere that leads to recovery flourishing. In combination with the first literature review it is clear that recovery is a joint responsibility of not just the service user but also practitioners and the wider community.

The aim in completing these reviews was to assess the current evidence-base for recovery and to discuss the differing discourses, which were currently prevalent. From completing this process it has become obvious that the recovery paradigm is gaining increasing prevalence across the spectrum of mental health provision. Central to achieving recovery is the provision of services, which are hopeful and optimistic and which recognize that mental illness is not a wholly negative experience. As Repper (2006) articulates it is through the process of recovery from mental ill health that service users can 'discover' their identity and this individual narrative is central to the ongoing development of the concept. However, this individual focus does

not negate the responsibility of services and the community to promote activities, which aid recovery. For example, sport and arts were suggested as meaningful activities. Furthermore, the significance of education and employment to providing a social role and occupation is crucial.

We commenced this review by identifying that approximately 60% of the literature around recovery has been written since 2006. It is certainly true that the evidence-base for the concept is vast and continues to grow at a rapid rate. However, the review process has identified obvious omissions. There is very little theoretical evidence presented for recovery in mental health, which draws together the differing views and discourses. Similarly, there is a lack of empirical research, which investigates recovery in a systematic way. Throughout both phases of the review it has been commented that there is a contradiction within policy between the duties to provide recovery-orientated services with the responsibility to minimize risk. This dilemma permeates both service development and individual practice. However, if the recovery concept is not clearly articulated in theoretical terms with an empirical evidence-base to support it, it is difficult to see how this situation can be rectified. For recovery to be more clearly articulated and less open to manipulation from differing discourses the theoretical and empirical evidence now needs to be provided to support the continuing evolution of the concept.

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