



The British research evidence for recovery, papers published between 2006 and 2009 (inclusive). Part One: a review of the peer-reviewed literature using a systematic approach

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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 few articles that review the recovery literature; furthermore, articles that report research directly related to the recovery concept are scarce.
- Originally, the focus of the recovery movement was upon the role of the individual in their own recovery journey; there has been a shift towards the responsibility of service providers to ensure a recovery focused service.
- Tensions have emerged in the literature between the humanistic philosophy of recovery and the biomedical model that has historically informed psychiatry. Similarly, the notion of recovery may overemphasize the significance of personal agency against the responsibility of services to fulfil a duty of care.
- Recovery has become strongly associated with social roles and meaningful activities including education, work and engagement with sport and arts activities.

Abstract

This paper is the first in a series of two which reviews the contemporary British evidence-base relating to recovery in mental health over a 4-year period. This review uses a systematic approach analysing the British peer-reviewed literature relating to recovery and mental health. The second paper in the series reviews the non-peer-reviewed literature. Recovery is not a new concept; however, it has recently become increasingly prevalent in practitioner, policy and research discourses. In total 12 papers met the inclusion criteria. Five main themes emerged from the analysis: hope and optimism, meaning to life, activities promoting recovery, definitions and discourses and implications for mental health practice. By including only peer-reviewed literature this paper is in a strong position to analyse the theoretical development of the recovery concept and highlight future directions for recovery in mental health services.

Introduction

Since the last published review of the British literature (Bonney & Stickley 2008), the concept of recovery in mental health has become increasingly prevalent in practi-

tioner, policy and research discourses. The rise in the number of published articles devoted to the concept of recovery has been noticeable. Judging by the results of various unrefined searches, we estimate that approximately 60% of all the literature focusing upon recovery and

mental health has been published in the last 4 years, giving rise to the need for this review.

Recovery in mental health is not an easy concept to define or articulate. Although this review is concerned with the British literature, there have been contributions to the development of the concept from around the world. Recovery is linked to the growth of service user/survivor movement in the 1980s and 1990s in the USA and elsewhere and some of the first attempts to define the concept were by Deegan (1988) and Anthony (1993). Deegan (1988) identifies that recovery is a process whereby people accept the challenge of being socially disabled by their mental ill health and recover a new sense of self. As such, she was the first to propose a non-medical definition of recovery in mental health. Anthony (1993, p. 527) developed some of these ideas further by arguing that ‘. . . recovery involved the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness’. Since these early descriptions a plethora of work has continued to expand the conceptualizations of recovery. For example, Warner (2004) identified two common uses of the word recovery: the first meaning the loss of previous psychiatric symptoms and a return to former health (complete recovery) and the second a more social recovery, for example, returning to work but maintaining some symptoms. Davidson *et al.* (2005) offer a conceptual framework based on four different definitions:

1. A return to normal functioning.
2. An act, instance, process or period of recovering.
3. Something gained or restored in recovering.
4. The act of obtaining usable substances from unusable sources.

This description was not specific to mental health and is used to classify recovery within health care as a whole. However, Davidson *et al.* (2005) argue that once described in this way it is clear that different forms of recovery can exist within the context of a person’s life. Viewing recovery across the entire spectrum of health care enables an appreciation of the different ways people manage to live with various combinations of different conditions (Davidson *et al.* 2005). Onken *et al.* (2007) propose an ecological framework that attempts to merge the medical versus personal understandings of recovery, through what they refer to as first and second order change. Similarly, Resnick *et al.* (2005) reject the potential division between conceptualizing recovery as either process or outcome. Instead, through a factor analysis of existing data from a large-scale study of people with a diagnosis of schizophrenia, they conclude that according to this client group, recovery may be conceptualized such: ‘. . . the capacity to feel empowered in one’s life; self-perceptions of knowledge about mental illness and available treatments; satisfaction with quality of

life; and hope and optimism for the future’ (Resnick *et al.* 2005, p. 125). In the UK, Repper & Perkins (2003) reject universal definitions of recovery and favour those that are individual and subjectively determined.

In this series of two papers we have deliberately separated the findings to establish whether there is an empirical and theoretical evidence-base emerging directly related to the concept of recovery in mental health in the UK. In particular, given the wide-scale policy framework supporting recovery, as we commenced these reviews, we were keen to identify relevant theoretical and empirical research that was lacking from previous reviews (for example, Bonney & Stickley 2008). We also aimed to identify any dissenting voices from mainstream policy or practice, or those critical of the recovery concept. By doing this we hope that these two reviews will advance the existing knowledge and discussion around the subject area. The first review therefore focuses on the peer-reviewed research around recovery and is reported in this paper. The second article reviews the non-peer-reviewed literature including books, book chapters, policy documents, opinion articles, editorials and individual narratives. By taking this approach we hope to advance the existing knowledge and discussion around the subject area and we also seek to analyse the gaps between research, policy and practice and make recommendations for further examination of the concept.

Aim

The overall aim of both phases of the review was to analyse the contemporary British literature related to recovery in mental health. ‘Contemporary’ is used to refer to articles published in the 4-year period 2006 to 2009 (inclusive). In this paper we discuss the first phase of the review, which focused purely on articles and studies, which were published in peer-reviewed journals.

Search strategy

To be included in either phase of the review, studies had to meet the criteria of focusing upon recovery in mental health and be UK-orientated papers. Initial searches using the terms ‘recovery’ (in the title) and ‘mental health’ (in subject or keyword) in the following databases yielded 512 papers; ASSIA, British Nursing Index, CINAHL, EMBASE, MEDLINE, PSYCHINFO, Web of Science and Web of Knowledge. The search strategy was deliberately over-inclusive to prevent pertinent articles being missed and there were no restrictions placed on the study or article type (for example, quantitative, qualitative, narrative or theoretical). The following limits were then applied to further focus the search; published between January 2006

and December 2009, English language, related to adult mental health (not Child and Adolescent services) and have a UK focus. Where it was possible to do so, these limits were applied electronically; otherwise the titles and abstracts were checked manually by the reviewers. At this point there were 84 articles eligible for inclusion and following the removal of duplicates 62 papers remained.

To check the search strategy was as accurate as possible we ran a separate search using the terms 'recovery' (title) and 'mental illness' (subject/keyword) in the databases previously listed. Only two further papers were identified and included in the review (the total at this point was 64). We also hand searched the following journals: Social Science and Medicine, Sociology of Health and Illness, Journal of Psychiatric and Mental Health Nursing, British Journal of Psychiatry and the British Medical Journal. These journals were selected as a means of checking that the database searches had incorporated a wide range of different disciplines, for example, sociology, medicine and nursing. The 64 papers were further limited by being excluded if they focused on workforce development (for example, role descriptions of support, time and recovery workers) or exclusively on substance misuse or addictive behaviours. Following a closer review of the abstracts it became apparent that a number of articles did not directly focus on recovery but used the term in the title (for example: Melvyn 2006, Stickley & Felton 2006, Higginson & Mansell 2008, Jones & Evans 2008, Oldknow & Grant 2008, Hughes *et al.* 2009, Jones 2009).

The full paper versions were obtained for the remaining 47 articles and each was read by the two reviewers independently. If the reviewers disagreed on the relevance of a paper the view of an independent expert was sought. Following analysis of the full papers a further 24 articles were excluded. Table 1 lists the excluded papers and our reasons for their exclusion.

A further paper was excluded because of the similarity between it and another written by the same authors (Buchanan-Barker & Barker 2006, 2008). It was felt that including both papers was 'double counting' and so only Buchanan-Barker & Barker (2008) was included in the review. Twenty-three papers therefore fulfilled the criteria for inclusion in the review. These are listed in Table 2.

These 23 remaining papers were then divided into those that were peer-reviewed and those that were grey or non-peer-reviewed literature. This left 12 articles to be included in first phase (peer-reviewed) and 11 in the second phase (non-peer-reviewed) of the literature review.

To analyse and synthesize the selected papers an approach similar to Bonney & Stickley (2008) was used. The papers were read several times to identify similarities, discrepancies and omissions. Significant points were high-

lighted and emerging themes listed and discussed between the two reviewers. To synthesize the findings, related themes were linked together as suggested by Aronson (1994). To maintain a transparent approach personal beliefs, biases and assumptions were acknowledged throughout the process (Parahoo 1997).

Findings

Twelve articles were identified within the peer-reviewed literature. Six were theoretical papers (Ramon *et al.* 2007, Buchanan-Barker & Barker 2008, Pilgrim 2008a, 2009, Roberts 2008, Shiers *et al.* 2009), four described empirical research (Emslie *et al.* 2006, Spandler *et al.* 2007, Carless & Douglas 2008, Fowler *et al.* 2009a) and two were literature reviews [Bonney & Stickley 2008 (limited to British literature); Cleary & Dowling 2009 (world-wide)]. The included studies originated from authors from a range of different disciplines, for example, sociology (Pilgrim 2008a, 2009), social science (Emslie *et al.* 2006), nursing (Bonney & Stickley 2008, Roberts 2008) and medicine (Fowler *et al.* 2009b). One paper (Shiers *et al.* 2009) was written by carers, none was written by individuals who identified themselves as mental health service users. Of the empirical papers three were qualitative by design and the other was a quantitative retrospective study.

Five broad themes were identified from the 12 papers. These appeared to be indistinct at times and studies interweaved between themes not fitting wholly into one or another; this was similar to the review authored by Bonney & Stickley (2008). The broad themes identified were:

1. Hope and optimism.
2. Meaning to life.
3. Activities promoting recovery.
4. Definitions and discourses.
5. Implications for mental health practice.

Each of these themes are now considered in turn.

Hope and optimism

Hope and optimism was identified as a key theme both in relation to providing services, which lead to recovery (Ramon *et al.* 2007, Shiers *et al.* 2009) and within the wider discourse of mental health (Roberts 2008). Shiers *et al.* (2009) and Ramon *et al.* (2007) highlight that mental health services have a 'duty' to provide hopeful and therapeutically optimistic services. This duty may be overlooked in the individual focus of the language of recovery (Ramon *et al.* 2007). Often mental illness is perceived to be 'life destroying', which projects a hopeless view of an individual's situation (Shiers *et al.* 2009). However, Roberts (2008) using Nietzsche's concept of 'eternal return' argues that

Table 1
Table of excluded studies

Article details	Reason for exclusion
Allen D. (2008) Sowing seeds of recovery. <i>Mental Health Today</i> July 2008, 9	Service description
Aslan M. & Smith M. (2008) Recovery and beyond. <i>Mental Health Today</i> March 2008, 36–37	Recovery training programme and manual
Barton G. et al. (2009) Cognitive behaviour therapy for improving social recovery in psychosis: cost effectiveness analysis. <i>Schizophrenia Research</i> 112, 158–163	Cost effectiveness of a CBT intervention
Bassett H. et al. (2008) Approaching in the right spirit: spirituality and hope in recovery from mental health problems. <i>International Journal of Therapy and Rehabilitation</i> 15, 254–259	Australian paper
Cooper P. et al. (2008) A 24 hour recovery vehicle? <i>Mental Health Nursing</i> 28, 14–17	Service evaluation
Dickens G. (2009) Mental health outcome measures in the age of recovery based services. <i>British Journal of Nursing</i> 8, 940–943	Focuses on HoNOS rather than recovery
Dinniss S. et al. (2007) User-led assessment of a recovery service using DREEM. <i>Psychiatric Bulletin</i> 31, 124–127	Service evaluation
Fowler D. et al. (2009a) Cognitive behaviour therapy for improving social recovery in psychosis: a report from the ISREP MRC Trial Platform study. <i>Psychological Medicine</i> 39, 1627–1636	Evaluates the SRCBT intervention
Hawkes D. & Hingley D. (2007) Recovery intelligence and 'groundhog day' effect in mental health care. <i>Mental Health Nursing</i> 27, 18–19	Advice to nurse conducting assessments
Higgins A. & McBennett P. (2007) The petals of recovery in a mental health context. <i>British Journal of Nursing</i> 16, 852–856	Irish
Higginson S. & Mansell W. (2008) What is the mechanism of psychological change? A qualitative analysis of six individuals who experienced personal change and recovery. <i>Psychology and Psychotherapy: Theory, Research and Practice</i> 81, 309–328	Focuses on non-mental health conditions such as chronic fatigue and post abortion
Hughes R. et al. (2009) Patients perceptions of the impact of involuntary inpatient care on self, relationships and recovery. <i>Journal of Mental Health</i> 18, 152–160	Involuntary treatment is the main focus rather than recovery
Jones A. (2009) Football as a metaphor: learning to cope with life, manage emotional illness and maintain health through to recovery. <i>Journal of Psychiatric and Mental Health Nursing</i> 16, 488–492	Football as an intervention
Jones G.H. & Evans A. (2008) Hope, help and recovery. <i>Mental Health Practice</i> 11, 32–37	Service development
Kelly J. et al. (2009) HEART – the Hounslow Early Active Recovery Team: implementing an inclusive strength based model of care for people with early psychosis. <i>Journal of Psychiatric and Mental Health Nursing</i> 16, 569–577	Service evaluation
Khan Q. (2006) Spiritual and cultural care in recovery. <i>A Life in the Day</i> 10, 24–28	Service evaluation
Malik N. et al. (2009) Effectiveness of brief cognitive behavioural therapy for schizophrenia delivered by mental health nurses: relapse and recovery at 24 months. <i>Journal of Clinical Psychiatry</i> 70, 201–207	Focuses on brief CBT as an intervention
Melvyn M. (2006) Rights, relationships and recovery. <i>Mental Health Nursing</i> 26, 8–9	Training
Oldknow H. & Grant G. (2008) Does joining a football academy help mental health recovery? <i>Mental Health Nursing</i> 28, 8–11	Focuses on football
Sass B. et al. (2009) A learning and action manual to improve care pathways for mental health and recovery among BME groups. <i>International Review of Psychiatry</i> 21, 472–481	Presents a manual for voluntary sector staff to improve pathways into care for BME groups
Shepherd G et al. (2008) Putting recovery into mental health practice. <i>Mental Health Today</i> May 2008, 28–31	Summary of a policy document – full document included in second phase of review
Slade M. et al. (2009) Methodologies for evaluating recovery training. <i>Clinical Psychology Forum</i> 193, 10–15	Evaluation of a staff training programme
Stott K. (2008) Steps towards recovery. <i>Nursing Standard</i> 22, 61	Training focus
Whitley R. & Prince M. (2006) Can urban regeneration programmes assist coping and recovery for people with mental illness? Suggestions from a qualitative case study. <i>Health Promotion International</i> 21, 19–26	Urban intervention focus

mental distress can enrich a person's life and add greater meaning to it. By using 'eternal return' to inquire about mental health problems, professionals can be hope inspiring and promote recovery (Roberts 2008). Similarly, Shiers et al. (2009) argue that individual story-telling can encourage ownership of life and experiences. The values and

attitudes of services and those who work in them are highlighted as crucially important to the promotion of recovery (Buchanan-Barker & Barker 2008). As Ramon et al. (2007, p. 118) summarize:

All service providers and purchasers would need to change their attitudes and move away from not only the

Table 2

The included papers

Details of included papers	
Peer-reviewed	Non-peer-reviewed
Bonney S. & Stickley T. (2008) Recovery and mental health: a review of the British literature. <i>Journal of Psychiatric and Mental Health Nursing</i> 15 , 140–153	Blank A. & Hayward M. (2009) The role of work in recovery. <i>British Journal of Occupational Therapy</i> 72 , 324–326
Buchanan-Barker P. & Barker P. (2008) The Tidal Model commitments: extending the value base of mental health recovery. <i>Journal of Psychiatric and Mental Health Nursing</i> 15 , 93–100	Craig T. (2008) Recovery; say what you mean and mean what you say. <i>Journal of Mental Health</i> 17 , 125–128
Carless D. & Douglas K. (2008) The role of sport and exercise in recovery from serious mental illness: two case studies. <i>International Journal of Mens Health</i> 7 , 137–156	Faulkner A. (2007) The recovery bandwagon will need to travel slowly and carefully if it is to take everyone with it. <i>Mental Health Today</i> October 2007, 26
Cleary A. & Dowling M. (2009) The road to recovery. <i>Mental Health Practice</i> 12 , 28–31	Gilespeie M. & Clarke A. (2009) Recovery group for people with severe and enduring mental health problems. <i>Clinical Psychology Forum</i> 172 , 15–18
Emslie C. <i>et al.</i> (2006) Men's accounts of depression: reconstructing or resisting hegemonic masculinity? <i>Social Science and Medicine</i> 62 , 2246–2257	Lester H. & Gask L. (2006) Delivering medical care for patients with serious mental illness or promoting a collaborative model of recovery? <i>British Journal of Psychiatry</i> 188 , 401–402
Fowler D. <i>et al.</i> (2009b) Can targeted early intervention improve functional recovery in psychosis? A historical control evaluation of the effectiveness of different models of early intervention service provision in Norfolk 1998–2007. <i>Early Intervention in Psychiatry</i> 3 , 282–288	O'Hagan M. (2008) Recovery: the true meaning of recovery. <i>Mental Health Today</i> December 2008, 16–17
Pilgrim D. (2008a) Recovery and current mental health policy. <i>Chronic Illness</i> 4 , 295–304	Petch A. (2008) Mental health recovery. <i>Community Care</i> 1708 , 32–33
Pilgrim D. (2009) Recovery from mental health problems: scratching the service without ethnography. <i>Journal of Social Work Practice</i> 23 , 475–487	Ramsey C. & Till U. (2009) A long and emotional story from illness to recovery. <i>Mental Health Practice</i> 12 , 30–34
Ramon S. <i>et al.</i> (2007) Recovery from mental illness as an emergent concept and practice in Australia and the UK. <i>International Journal of Social Psychiatry</i> 53 , 108–122	Repper J. (2006) Viewpoint: discovery is the new recovery. <i>Mental Health Today</i> February 2006, 37
Roberts M. (2008) Facilitating recovery by making sense of suffering: a Nietzschean perspective. <i>Journal of Psychiatric and Mental Health Nursing</i> 15 , 743–748	Schrank B. & Slade M. (2007) Recovery in psychiatry. <i>Psychiatric Bulletin</i> 31 , 321–325
Shiers D. <i>et al.</i> (2009) Beyond early intervention: can we adopt alternative narratives like 'woodshedding' as pathways to recovery in schizophrenia. <i>Early Intervention in Psychiatry</i> 3 , 163–171	Stowers C. <i>et al.</i> (2009) Recovery of what by whom? <i>Clinical Psychology Forum</i> 196 , 50–53
Spandler H. <i>et al.</i> (2007) Catching life: the contribution of arts initiatives to recovery approaches in mental health. <i>Journal of Psychiatric and Mental Health Nursing</i> 14 , 791–799	

deficit model, but also from the pessimism inherent in the system as well as be more ready to undertake calculated risks.

Fowler *et al.* (2009b) demonstrate that when services do have the infrastructure to support optimistic practices (for example, being a dedicated early intervention team) positive outcomes can be achieved; in this case, gaining employment or remaining in full time education.

Meaning to life

Mental illness was not a wholly negative experience and could potentially enrich and add meaning to a person's life. Roberts (2008) identifies that mental distress can

add meaning to one's life as the experience increases self-awareness and personal growth. Spandler *et al.* (2007) found that a sense of purpose and meaning to life was a key theme emerging from the arts projects being evaluated. Indeed being involved in a range of different activities (for example, art, sport or education) was found to increase meaningful experiences. Perceiving mental illness to be a meaningful experience had a clear link to optimism and hopefulness as described above (Ramon *et al.* 2007, Shiers *et al.* 2009). By having an optimistic and hopeful outlook the sense of meaning in the experience of mental illness is increased and an individual's sense of identity is enhanced (Shiers *et al.* 2009). Emslie *et al.* (2006) took this a step further and focusing purely on men's experiences of depression argues that

recovery was dependent on being able to find meaning in experiences and reconstructing a valued sense of self and masculinity.

Activities promoting recovery

Activity has a crucial role in promoting recovery in mental health and the empirical research identified through the review process focused predominantly on either activity interventions (Spandler *et al.* 2007, Carless & Douglas 2008) or the value of mental health services engaging individuals in activity (Fowler *et al.* 2009b). The arts (Spandler *et al.* 2007), physical activity (Carless & Douglas 2008) and education and employment (Fowler *et al.* 2009a) were particularly emphasized. Spandler *et al.* (2007) found that through engagement in arts projects interview participants reported improved coping strategies, increased self-expression and social support, a sense of purpose and a rebuilding of identities. Similarly, Carless & Douglas (2008) found by engaging in sport it was possible for individuals to both return to activities that were intrinsically meaningful and for it to be used as a vehicle for desired outcomes and meaningful vocational activities. Sport and exercise, therefore, were seen to represent a fresh start and a worthwhile use of time (Carless & Douglas 2008).

As well as being therapeutic in themselves, engagement in activity was also highlighted as an outcome for achieving recovery and a measure of success for mental health services (Fowler *et al.* 2009b). Fowler *et al.* (2009b) retrospectively measured the success of early intervention teams in terms of how far they managed to promote 'functional recovery' that included employment or enrolment in education. Recovery in this context clearly has an objective and observable end product, which provides an alternative to the more qualitative indicators of improved self-esteem and increased meaning in life.

Definitions and discourses

How the concept of recovery is defined and the language used has become increasingly debated as it has been incorporated into mainstream mental health services (Ramon *et al.* 2007, Pilgrim 2008a, 2009). Ramon *et al.* (2007) argue that with the adoption of the language of recovery there is an increasing need for critical appraisal. For example, with the pursuit of evidence-based medicine and measurable outcomes, the significance of narrative and user definitions of recovery may become sidelined (Ramon *et al.* 2007) and increasingly narrow definitions of what it constitutes enforced. This final point is clear in the definition of 'functional recovery' proposed by

Fowler *et al.* (2009b). Pilgrim (2009) argues that it is currently difficult to make assertions about what recovery is or is not due to a lack of ethnographic research into questions such as how should it be most appropriately described, how does it arise and how is it maintained? Without this research, accounts of recovery can only be based on subjective positions and Pilgrim (2009, p. 485) argues that at the present time: 'If recovery can vaguely mean anything in our current discussions does it mean anything at all?' Pilgrim (2009) draws on a previous paper (Pilgrim 2008a), which outlines a history of the adoption of recovery principles in the UK. This also adds an alternative definition to those consistently referred to in the mental health arena as service users or survivors, Pilgrim regards people in terms of their 'social survival'. This definition rejects the need for professional intervention and it is claimed to be the view of user critics (Pilgrim 2008a). Structural factors are also argued to have a bearing on whether recovery is achievable. Racism, poverty and unemployment are examples of powerful social forces, which militate against recovery (Pilgrim 2008a).

Implications for practice

Bonney & Stickley (2008) argue that those delivering mental health services need to be flexible to deal with the paradigm shift that the concept of recovery in mental health entails. Furthermore, Ramon *et al.* (2007) and Shiers *et al.* (2009) argue there is a need for professionals and services to have a therapeutically optimistic approach to those with mental health problems and to find meaning in the experiences of mental distress. The values and attitudes of those providing 'hands on' care is crucial to this (Buchanan-Barker & Barker 2008) and Pilgrim (2008a) highlights that there are inevitable tensions between the rhetoric of recovery-orientated policy and what may go on in professionals minds when they are dealing with their patients. While there may be a difference between the rhetoric of recovery in practice and reality of care, Ramon *et al.* (2007) highlight that mental healthcare providers have a duty to provide services that promote recovery. The studies by Carless & Douglas (2008) and Spandler *et al.* (2007) indicate that the provision of activities that allow for meaningful participation and social inclusion such as the arts and sport may be one way of doing this. Pilgrim's (2008a) suggestion that recovery is also dependent on social factors such as racism and poverty indicates that responsibilities for promoting it lie wider than healthcare providers alone, for example, in the development of communities and tackling the wider determinants of poverty and inequality.

Discussion

Although relatively small in number, the peer-reviewed papers identified in this review have drawn on a wide range of disciplines to further the theoretical development of recovery in mental health. Recovery is a complex concept, not clearly defined and in need of further debate and clarification (Ramon *et al.* 2007, Pilgrim 2009). Having attitudes and values that are congruent with recovery is central (Buchanan-Barker & Barker 2008, Shiers *et al.* 2009) and it is clear that there is a duty on services to work in such a way that recovery is promoted (Ramon *et al.* 2007).

By reviewing only peer-reviewed articles, this review (to a degree) lacks opinion pieces and editorial commentary. Furthermore, with the exception of Shiers *et al.* (2009) the review also lacks personal narratives that are common within the recovery literature. Moreover, as the review does not include policy, it is also relatively free from rhetoric. A review of this nature therefore is in a strong position to analyse the theoretical development of the recovery concept. There are a number of facets of recovery that have been reaffirmed in this review of recent peer-reviewed British literature. These may be summarized as:

- There is no universal definition of recovery.
- Personal recovery is strengthened by approaches from services that are respectful, hopeful and informed by a humanistic philosophy.
- Individual narrative is central to the recovery paradigm.
- People may draw meaning from their mental distress.
- There are tensions between delivering services that are both recovery-orientated and risk averse.
- Meaningful occupation is central to individual recovery.

Recovery from mental health problems appears therefore to need a coordinated and multifaceted response from a diverse range of services and a need for more research into what it means and how it is maintained (Pilgrim 2009). However, recovery as a discourse originally grew from the experiences of those who use mental health services and as Ramon *et al.* (2007) identify there is a danger that in the pursuit of definition, clarity and interventions that promote recovery the service user voice and narrative may become lost. It remains to be seen whether it is possible to bring together service users' wishes and service provider obligations into a coherent system for mental health care. It is worth observing that a critical service user perspective is offered in the Mind report: '*Life and times of a supermodel. The recovery paradigm for mental health. MindThink report 3*' Mind (2008) and other non-peer-reviewed publications that are discussed in the second article in this series.

What is clear from the literature is the developing critical analysis around the concept of recovery. The clash between individual narratives and subjective definitions of recovery are also seen to be at odds with the priorities of evidence-based medicine (Ramon *et al.* 2007, Buchanan-Barker & Barker 2008). There are voices being raised that are sceptical of services ever truly being able to deliver a recovery approach (Bonney & Stickley 2008). Furthermore, mental health services continue to exert coercive social control while implementing recovery approaches and professionals are often seen as part of the problem rather than the solution (Pilgrim 2008b). Identifying obstacles to the implementation of recovery policy in the UK, Ramon *et al.* (2007, p. 118) state that:

All service providers and purchasers would need to change their attitudes and move away from not only the deficit model, but also from the pessimism inherent in the system, as well as be more ready to undertake calculated risks.

With the adoption of the language of recovery in health service provision, there needs to be a constant critical appraisal of the concept (Ramon *et al.* 2007). For example, the notion of recovery may overemphasize the significance of personal agency against the responsibility of services to fulfil a duty of care. Within the literature it is evident that there is a move away from recovery as an individual's responsibility towards services and the wider community fulfilling their responsibilities and duty of care. What has become apparent in this study is the need for the provision of socially inclusive activities such as arts and sports (Spandler *et al.* 2007, Carless & Douglas 2008).

There is some emerging evidence of good practice in promoting recovery through meaningful activity (Emslie *et al.* 2006, Spandler *et al.* 2007, Carless & Douglas 2008). The concept of social inclusion, while closely remaining an ally of the recovery agenda, should not be oversimplified; as Spandler *et al.* (2007, p. 797) observe in their study, participants greatly valued their involvement in their mental health specific arts projects. 'As a number of service users have pointed out, people with mental health difficulties do not necessarily want to be part of a mainstream society that has rejected them.' As well as mental ill health causing potentially catastrophic sociopolitical and economic consequences (Roberts 2008), there is a growing understanding of the relationship between people's social positioning and their mental health (Pilgrim 2008a). The risk agenda, however, fuels negative stereotypes of mental illness: 'With such a current focus upon risk in Western society (Beck 1992), it is virtually inconceivable that statutory health care providers will ever fully embrace the recovery paradigm that involves self-management and has

choice, hope, freedom and autonomy at its core.’ (Bonney & Stickley 2008, p. 150).

Contribution to current knowledge and theory

Bonney & Stickley (2008) was the first review of the British recovery literature. As such, they have provided a unique overview of the subject especially in their synthesis and analysis of the literature from various discourses. They found consensus that good-quality care should be made available to service users; however, they identified that the way in which recovery was defined and delivered differed between the groups. Buchanan-Barker & Barker (2008) emphasize the need for values to inform recovery-orientated practice. Their ‘Tidal Model’ to which the article refers is a recovery-focused mental health nursing model based upon humanistic theory and emphasizes the role and voice of the individual person in their own recovery. Their ‘10 Commitments’ provides a framework for understanding and practising the essential values for work that promotes recovery.

This review has found some empirical research that supports the role of social activities to promote recovery. Emslie *et al.* (2006) make a valuable contribution with regards to the place of the development of an individual valued sense of self and self-identity through social relationships; Spandler *et al.* (2007) through participation in the arts; Carless & Douglas (2008) through physical activity. Fowler *et al.* (2009a) clearly identify the potential for recovery through education and employment. It is worth noting that there are many published articles identifying the benefits of participating in meaningful activities, education and employment; however, they would not have been included in this study if they did not explicitly relate these benefits to the concept of recovery in mental health. Roberts (2008) provides a rare theoretical critique of the concept of recovery and illustrates how mental distress can enrich a person’s life and add greater meaning to it. While this approach has been evident in the service user literature, there has previously been an absence of theory to support this. Shiers *et al.* (2009) is a unique paper in that while it is based upon the experiences of the authors, it also discusses theoretical aspects of recovery and directs the learning from this combination towards practice. Perhaps this blend of experience, theory and practice is an exemplar for future theory and research development in recovery.

There remain gaps in the conceptual development of recovery in mental health. For example, while humanistic principles are intrinsic to the recovery discourse (Ramon *et al.* 2007, Shiers *et al.* 2009), there is little in the literature that explicates this. Authors such as Buchanan-Barker &

Barker (2008) identify core values, which promote recovery. However, it is not clear whether these work for everyone, all of the time. To coin the terms that Rogers (1951) used it is not clear which of these values are sufficient and which are necessary for recovery in mental health.

While recovery language becomes mainstream in mental health policy, there is a danger that the statutory discourse subsumes the essence of the service user discourse (Bonney & Stickley 2008), especially with the statutory preoccupation with risk avoidance set against the recovery ethos of risk taking (Cleary & Dowling 2009). Furthermore, statutory discourse emphasizes the significance of personal agency against the responsibility of services to fulfil a duty of care (Ramon *et al.* 2007) and in terms of a sociopolitical critique, Pilgrim (2008a; 2009) makes an effort to highlight the significance of social structures that influence the individual’s ability to recover. It is now being made clear that empirical research is essential for the development of recovery theory for both an understanding of what recovery means to the individual and to services, and what it means for people in society (Ramon *et al.* 2007, Pilgrim 2009).

Conclusion

In recent years, there has been a sharp rise in the number of articles relating to recovery and mental health in the UK, although very few have been in peer-reviewed journals. There has therefore been very little published that contributed to the development of recovery theory and its evidence-base. Of the 12 articles that were included in our study, only three of these were articles reporting upon empirical research studies. It is interesting to note that there is a shift within the literature and recovery is no longer the responsibility of the individual but mental health services and communities more generally have a responsibility or to use what Ramon *et al.* (2007) refer to as a ‘duty’ to promote recovery for people with mental health problems. At the current time it is difficult to determine whether this more structural approach will become more dominant in the recovery discourse or whether these will remain as ‘dissenting voices’.

There remain tensions between the coercive nature of mental health law and the humanistic philosophy enshrined within the recovery paradigm. This is further complicated by the clash between the biomedical philosophy that has historically dominated psychiatry and the emerging philosophy of the recovery paradigm.

While the debate regarding recovery continues to progress it remains to be seen whether it is possible to marry up the discourses in the peer-reviewed literature

with the rhetoric of recovery in policy and the subjective accounts (from users, clinicians and academics) reported in the grey/non-peer-reviewed evidence-base. It is by combining the findings from this review with the second in the

series that more light can be cast on the state of the evidence-base for recovery in mental health in the UK and the tensions and dilemmas from the different discourses can be more thoroughly explored.

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