

Recovery and Spiritual and Pastoral Care Services: A Working Model

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In what follows, I provide a brief overview of the recovery training programme running at present within the South London and Maudsley NHS Foundation Trust, and the contribution of the Trust's Spiritual and Pastoral Care Service to this programme. Further, I offer reflections arising out of the experience of being involved with this programme so far.

South London and Maudsley NHS Foundation Trust (SLaM) has recently decided to develop a recovery-focused approach to its work, as outlined in its *Social Inclusion, Rehabilitation and Recovery Strategy, 2007-2010*. Its own working definition of recovery is that it involves 'living as well as possible', and the strategy outlines a number of elements for delivering recovery-oriented practice intended to support service users in their recovery journey.

SLaM's Recovery Training Programme

At present in SLaM we have a recovery training programme which is targeting mental health teams in Southwark and Lambeth directorates (approximately 300 practitioners - nurses, doctors, social workers, occupational therapists, support workers, psychologist, managers, admin staff etc.) who are working with people with severe mental health problems.

The aim of the training is to promote attitudes and values supporting and maintaining recovery, as well as the development of specific skills in working with service users and their carers.

The training consists of a series of workshops (four and a half days), covering selected recovery aspects and focusing on themes such as the importance of hope, holistic treatment and service user involvement in the recovery journey.

The training program will be evaluated, with staff and service users' questionnaires being administered before and after the training programme. The results of the evaluation will be prepared into a report, the outcomes of which will be fed back to the service (Forzisi and Oduola 2007).

Why are the Spiritual and Pastoral Care Service involved?

The Spiritual and Pastoral Care Service was asked to contribute to this programme because the steering committee for the training programme recognised the importance of spirituality in recovery and recovery-oriented practice. Much of the available literature on recovery and the recovery philosophy, not least 'first person accounts' from users of mental health service users, is suffused with references to spirituality and its importance in

the recovery journey. One such example is Sally Clay's (1999, 35) own testimony:

We who have experienced mental illness have all learned the same thing... We know that we have reached the bare bones of spirit and of what it means to be human... There is something to be learned here about the mystery of living itself, something important both to those who have suffered and those who seek to help us. We must teach each other... knowing that it is often the wounded healer, or the wounded prophet, who is most able to help others... From the experience of madness I received a wound that changed my life. It enabled me to help others and to know myself. I am proud that I have struggled with God and with the mental health system. I have not recovered. I have overcome.

Policy and guidance documents speak also of the importance of attending to spiritual and religious needs. For example, the fifth principle of the National Institute for Mental Health in England's (NIMHE) *Guiding Statement on Recovery* (2005) states that:

Recovery from mental illness is most effective when a holistic approach is considered – including psychological, emotional, spiritual, physical and social needs.

Numerous research studies over the last three decades at least have evidenced the potentially beneficial impact that spirituality and religion can have on health and well-being as a whole and in coping with periods of adversity. More recently, the report from the *Rethink Self-Management Project* research (carried out by David Martyn in collaboration with forty-eight people with a schizophrenia diagnosis), noted how:

Many people's experiences had a spiritual dimension and, for some, self-management included taking up the challenge of understanding the meaning of their experiences.

For some, religious faith helped to maintain morale, and prayer provided a practical tool for enduring difficult times. The church or faith community could be a source of friends and acquaintances.

Religion could also be negative – a source of conflict and guilt, and being excluded by people who did not understand (Rethink 2003, 9).

The last comment is a salient reminder that spirituality and religion have the potential also to be less beneficial factors in mental health.

However, it is always a variable feast as to how the evidence and theories pertaining to the positive effects of spirituality and religion on mental well-being and coping strategies translate into practice across the care spectrum.

What ensures the engagement of my service with the training programme, and thus its contribution to raising rhetoric into practice within SLAM, is that many of the themes emerging within the contemporary focus on recovery are at the heart of the motivation for effecting spiritual and pastoral care in the mental health context. Thus, there are many points at which differing philosophies and ideologies (and, indeed, theologies) meet. For example:

- the safeguarding of human rights
- solidarity with some of the most vulnerable individuals in society
- social justice/social inclusion
- participating in the endeavour to reduce/eliminate stigma and discrimination
- building knowledgeable, understanding and accepting communities
- respecting the uniqueness of every human being
- hope
- meaning
- empowerment
- the value of lived experience and the importance of recognising how 'The person's sense of self, and world of experience... is inextricably tied to her/his life stories and their various associated meanings' (Barker 2001, 236)
- the re-claiming of one's sense of self
- the ongoing development of human potential and the ability to have an active part in creating one's future
- the importance of, and quality of, relationship
- believing that it is possible to be in a process of healing even though there may be no 'cure'
- believing that quality of life is possible even in times of adversity
- being able to see the 'person' behind the 'illness'

I suspect that most of my colleagues would find it difficult not basically to believe in the recovery movement, and in the reality that spirituality and religion, individuals' world views and philosophies, play a significant part in service users' coping strategies and restoration to health and well-being.

The nature of the involvement of the Spiritual and Pastoral Care Service in the training programme

As the training outline was being developed, I found myself on various occasions arguing for the recognition of the importance of spirituality in the programme. My intention in doing so was not just to develop ways in which we could assist practitioners to develop effective skills in responding to people's spiritual and religious needs. It was more about trying to remind my colleagues of the importance of this in service user's lives so that this dimension of recovery did not get lost amidst all the logistical implications of running the training programme.

The Spiritual and Pastoral Care Service is involved in two key ways: through the facilitation of team leader groups and through seminar input focusing on spirituality and recovery.

Team Leader groups

The steering committee for the training programme considered that supporting team leaders would be a major factor in maintaining recovery approaches. Both Southwark and Lambeth team leaders (whose teams would as a whole be involved in the training) were approached with this suggestion during an introductory seminar concerning the training. Subsequently, two groups were formed (one for Southwark and one for Lambeth directorates) and these are being led currently by two senior chaplains (including myself), meeting on average once per month.

The groups aim to support the formal training on a longitudinal basis, and thus to sustain the learning long after it ends. The groups provide a space for grappling with the realities of the culture shift required by working in recovery-oriented ways. It is a place also where recommendations for recovery-oriented practice can be developed and passed up to service manager/director levels when these are the levels more appropriate for issue resolution.

Practitioners' engagement with the groups was not too impressive at first, but this situation is improving now. As group facilitators, we had to take into consideration the resilience of our colleagues when exploring alternative approaches. We sensed that non-attendance was, amongst other factors, a systemic issue, linked to resistance to the training.

Spirituality and Recovery Seminars

The second strand of involvement is a session on *Spirituality and Recovery* on training day four, offered by the Spiritual and Pastoral Care Service, which has to be repeated fifteen times in order to reach all the practitioners engaged on the training programme.

One positive side-effect of the training programme is that it is assisting us as a team to reach a significant number of staff in order to discuss the interface of spiritual and religious issues and mental health care.

A constant motif (and aspect of resistance) that individuals have voiced through the training, and in the Spirituality and Recovery seminars, has been 'we're doing all that already' – the 'data' effect (personal communication). (See Davidson *et al* [2006] for other identified concerns about recovery and the transformation of mental health systems.) Of course, there are many examples of recovery-oriented work going on at present, and many examples of sensitive and appropriate spiritual care emerging within the training. The training needs to appreciate and value existing initiatives, while recognising

also that it is important for practitioners to keep their minds open to new ways of thinking, doing and being – a process at the heart of the recovery philosophy. The Spirituality and Recovery sessions have offered a number of practitioners a space to reflect on the interface of spirituality/religion and mental health for the first time in their career.

Reflections on the experience so far

Jacobson and Greenley (2001) have put forward a 'Conceptual Model of Recovery' (from service users' personal recovery accounts). For them, the word 'recovery':

...refers both to internal conditions – the attitudes, experiences, and processes of change of individuals who are recovering – and external conditions – the circumstances, events, policies, and practices that may facilitate recovery. Together, internal and external conditions produce the process called recovery (Jacobson and Greenley 2001, 2)

Jacobson and Greenley suggest that the internal conditions defining recovery include hope, healing, empowerment and connection, the external conditions focusing on human rights, a positive culture of healing and recovery-oriented services.

From a spiritual/pastoral perspective, one could suggest the external conditions are consonant with ensuring that people's religious and spiritual needs and resources are well respected in mental health treatment and care responses. Further, these needs and resources do not always come far down the list of care priorities (as some practitioners have suggested to me quite often happens). One could suggest also that the internal conditions (as well as, perhaps, a culture of healing) are consonant with a spirituality of recovery, on which I shall focus in the second part of my paper.

An angle that is emerging very strongly from my work with practitioners on the recovery training programme concerns the 'reciprocal' nature of the recovery process, which echoes Anthony's (1993, 10) notion that:

Recovery is a truly unifying human experience. Because all people (helpers included) experience the catastrophes of life (death of a loved one, divorce, the threat of severe physical illness, and disability), the challenge of recovery must be faced.

Indeed, how can one require a shift of consciousness (a notion at the heart of the recovery agenda) without attending to the needs of those who are required to make a shift of consciousness? Thus, I wish to widen the perspective somewhat concerning a 'spirituality of recovery'. Using Jacobson and Greenley's Conceptual Model of Recovery, I will offer reflections on their categories of 'a positive culture of healing', hope, healing and connection (relationship), taking into consideration the implications for practitioners concerning these elements as they focus more on recovery-oriented practice.

Creating a 'positive culture of healing'

If we can agree with the notion that recovery requires the creation of a positive culture of healing, then it is important to reflect on those elements making up such a culture. Jacobson and Greenley (2001, 3-4) focus on reciprocal processes where the environment is 'characterized by tolerance, listening, empathy, compassion, respect, safety, trust, diversity, and cultural competence.' In addition, an environment is called for where practitioners and service users are 'empowered and engaged', where there is commitment to change conceptualizations and practice, and a focus on strengths, goals and human rights. A major component is the 'development of collaborative relationships', where service users, providers/practitioners are able to 'see each other as human beings' - a veritable utopia perhaps, or an impossible dream?

How can working with a recovery-oriented process be possible, given the way the system works currently and the demands it places on people? There is a huge exponential increase regarding non-therapeutic demands on staff time. We are trapped culturally by measurement, obsessed by it perhaps. The emphasis on reporting is important but what gets short-changed is the therapeutic input.

This over-investment with doing (doing to) rather than being (being with) is emerging through the programme, as practitioners raise particular questions and issues, for example:

Where is there time for self-reflection in teams?

How can we work in the way that we want to with people when we are kept busy ticking boxes?

How can we talk about spirituality when we do not talk about it amongst ourselves?

Some practitioners are concerned about the 'repercussions' of working with spiritual and religious care and of working in more creative ways with service users. Others remember how there used to be more time to spend with each other and with service users. One spoke about the 'giving up of personal freedom' in the workplace now, and about having no space and time to do things that would be normal in any other job.

The focus on Recovery is an example of something new trying to break through, but trying to do so in a system that cannot always accommodate it easily in its present form. Much of this points to the need for a shift in the way the system works for recovery to become a reality. However, it is also about grounding the theory and suggestions for practice in a realistic way, recognising both the strengths and limitations of the system and the people who experience and are affected by the system. We do indeed need to see each other as human beings and to recover the respect and dignity that all of us hope for as we work with the healing endeavour. May (2007, 33) offers us his own poignant reflections concerning healing communities:

How can we recover healing communities? Communities that listen, that enable, that offer space for growth and change in a flexible way; communities that allow people to speak their truths, that create atmospheres of trust and allow people to choose ways forward in their lives, that enable conflicts to be peacefully resolved... The process of recovering healing communities is about creating communities of hope, of acceptance, of opportunity, of open-mindedness, of creativity, of understanding, of restorative justice, and of love.

Authentic, healing community only becomes a reality when people are in relationships that do not alienate or isolate and where the more vulnerable members of society are not further disadvantaged through inadequate attention to their needs.

Hope

The Ten Essential Shared Capacities (Department of Health 2004, 15) notes how important it is that practitioners understand the 'essential role of hope in the recovery process.' NIMHE's *Guiding Statement on Recovery* (2005) speaks about the necessity for the recovery process of encouraging hope. SLaM's *Social Inclusion, Rehabilitation and Recovery Strategy, 2007-2010*, adopts a slightly different perspective in recognising that 'staff need to have adequate resources and to feel hopeful about their own jobs if they are to promote hope in others.' But what is this 'thing' called hope?

Jacobson and Greenley (2001, 2) suggest that at its most 'basic' level, the hope leading to recovery is the belief that it is possible to recover. In addition, it is about 'focusing on strengths rather than weaknesses or the possibility of failure, looking forward rather than ruminating on the past' and recognising the importance of 'small steps' rather than 'seismic shifts'. Interesting also is their conceptualisation of hope as laying the 'groundwork for healing to begin', and that hope has something of the transcendent about it. Some evidence for this latter point can be found in Young and Ensing's (1999) findings from their research with eighteen 'mental health consumers' exploring the meaning of recovery:

For many of the participants, seeking out a source of hope and inspiration helped to foster the essential desire to change... A specific source of hope and inspiration discussed by many people was spirituality. It seems that severe illness is often perceived as something that is evil and uncontrollable, whereas God (or some other divine being or spirit) is seen as someone that is benevolent and dependable. Also noteworthy was the finding that reliance on spirituality generally increased as reported levels of suffering increased, and that faith helped several people survive their most severe crises (Young and Ensing 1999, 223).

The above helps us to see that hope is future-oriented and, very often, 'other-directed', in that we place our expectations concerning its realisation in something greater than ourselves. This reality captures its transcendent element. The Christian theologian, John Macquarrie (1982, 245) suggests that:

...most of our hopes do not even find expression in words, but they are tacitly implied in the future-oriented actions that we do... to act in hope implies the belief that the world has some openness in its texture, some space for freedom and creativeness, so that even if it is only to a small extent, each of us has some share in the shaping and transforming of the world.

Applied to healthcare, I know for myself how often I wonder about the ability and the courage that individuals have in keeping hope alive in the face of long-term distress, disempowerment and adversity. Hope at all times is an investment in one's self, something that holds for practitioners as well as service. The traditional view in mental health (now being challenged with the new focus on recovery) is that people do not get better. But when they do not get better, practitioners' hopes can be dashed and they too can lose heart. Davenhill (2004, 12) speaks about how practitioners can be left 'in the grip of a hopeless paralysis in terms of thoughtful functioning' or in a less than productive state concerning those in their care when perfect 'repair' is not possible. She suggests that the omnipotent expectations to cure that practitioners may place on themselves, or that organisations place on them, can become a 'burden that is impossible to fulfil.'

It is important in recovery that it is service users who define hope and the shaping of their futures. This alleviates practitioners of the necessity to define what hope is in a particular context, even though they do have to maintain their ability and courage to hope. Recovery can be about encouraging people to revive, and maybe revise, their notion of hope.

However, as Macquarrie (1982, 245) reminds us, there is another dimension to hope:

The more daring and imaginative the hope, the greater must be the trust in the future... It is the entertaining of large-scale hopes and visions of the future that promotes the criticism of existing institutions and opens the way for change. Hope is the spur to human transcendence on both the individual and social levels.

The challenge remains for all those interested in mental well-being to work together precisely to 'convert' the society we are in, to name the oppression, injustices and discrimination that can cause as well as prolong distress, illness and suffering and to hold the hope that it is possible to create communities that heal rather than harm.

Healing

Jacobson and Greenley (2001, 2) suggest that the concept of 'healing' captures recovery more than that of 'cure'. One can argue that 'healing', as linked to an authentic quest for wholeness, is part of the essence of being human, and is thus a concept that is intimately linked to the life of the spirit. This point is captured in the words of the contemporary spiritual writer, Thomas Moore (2004, 303):

A dark night of the soul can heal, where healing means being more alive and more present to the world around you. It heals by opening you up, sometimes to the point where you might feel dismembered. It opens the doorways between you and the world that heretofore have been closed. It reinstates the flow of life through you... this initiatory process is more difficult and sometimes more painful than treating your dark night as a problem needing a solution. It is never easy to accept more life, never easy to become more of who you are.

It might not always be possible to be 'cured', but it remains an ever open possibility that one can be in a healing process, that is, moving towards a greater understanding of one's own being and life experiences, and with a more integrated perspective on one's place in the whole, whatever state of health a person may be in at any given moment.

To understand this point and live this reality is to understand and accept the limits of modern medicine (and indeed alternative and complementary therapies), as well as other human limitations concerning responses to any kind of sickness, distress, disturbance or dysfunction. It is to accept also the finitude of human existence - the ultimate taboo.

In healthcare, the fundamental nature of any spiritual care is about connecting with people in the healing endeavour, where the emphasis is on clearing the way, allowing the space for something to happen - for healing to take place. One colleague spoke about the crucial nature (for both staff and service users) of having a physical space to see people – an environment that is healing, and an emotional/psychological space for reflection, and to form relationships with each other.

The primary motive for most of us who work as carers is to heal ourselves. Our ability to be in touch or not with that affects our work because the 'most important resource a carer has is themselves' (Lartey 1997, 42). Lartey suggests that carers need to be able to acquire ways and attitudes of being with people that will be most beneficial to the people who they are with. Crucial to this process is who they are, and who they are becoming, especially in their relationships with others. One may understand from this the importance for practitioners of being in their own, ongoing, healing process. On this note, Wright and Sayre-Adams (2000, 13) speak of the need for carers to be in 'right relationship' with themselves:

When we are in right relationship with ourselves, we discover the sacred space that is within. Thus grounded and centred in our own being, our own sacredness, we become available for the sacred to radiate into all aspects of our lives, not least our caring and healing work. Thus, we do not so much create sacred space, as become and be it. Who we are is the sacred. Who we are is the healer.

Exposure to different teams within the training is making me realise how foreign the concept of being in a healing process can be for some practitioners – as well as the notion of ‘spiritual care’ as applied to themselves. Many work within the framework of ‘doing to’ which means that their needs and forms of support are not important in the process. It is only when I work with the group in a more focused way on their own self-care that they begin to realise the gaps that exist in provision for their own care.

Connection/Relationship

Reciprocal working and relationships are mentioned often in the recovery literature as the way forward. Anthony (1993, 4) suggests that recovery is a ‘deeply human experience, facilitated by the deeply human responses of others.’ Jacobson and Greeley (2001, 3) note that recovery is a ‘profoundly social process’ and that what is being recovered is being in others’ company and ‘rejoining the social world.’

Spirituality can be a resource for people, but it can be seen also as at the heart of establishing a different quality of relationship between people. The *Rethink Self-Management Project* (Rethink 2003, 10) found that relationships with others were an essential factor in their respondents’ capacity to self-manage, offering them:

Encouragement
Exploration
‘Faith in me’
Positive expectations
Understanding
Practical help
Inspiration
Acceptance
Guidance
Support

Authentic relationship speaks to the spiritual dimension in all of us, because it awakens and nourishes those things in life that touch on the essence of our humanity.

One of the most striking things coming through in my involvement with this training is the negative energy and attitude surrounding us in the mental health context (not just in the media) - the jaded views we can hold of one another, and the competitive energies that can work against true collaboration but

which help to protect one's own sense of self in the work. These negative energies involve and affect service users, practitioners, institutions and systems as a whole. After all, there has to be someone or something to blame for all the pain, distress, dysfunction that we experience happening around us, which can dis-empower us, and which it is hard to live through and to find answers to.

Whilst we can recognise differing levels of competency and skill, there is also some humility and something 'sacred' perhaps in recognising that there are often no definite answers to the human condition, and all that we can do is to keep searching together in that quest for meaning (which also lies at the heart of any attempt to define the spiritual/the transcendent). This is captured well in Christopher Newell's (2008) words:

In this place, both personally and communally, there is a deep sense of the loss of identity that cannot but affect those prepared to 'professionally' come alongside. There is a sense of all of us exploring the unexplorable, in the implication of exploring what has yet to be revealed. We, all of us, seem to reside on the cusp of human identity, language and personality, attempting to help each other through and beyond the 'worldly' restrictions of sense and nonsense, reality and dreams, rationality, and what can only loosely be described as 'psychosis'. The angels always seem to be breaking through the psychiatrist's notebook.

Conclusion

This paper captures initial reflections on a practical initiative and a process linked to recovery and recovery-oriented working that I hope will gain strength and momentum as time progresses. The challenge will be to find ways in which to value these recovery initiatives and not just to dismiss them as yet another fad in mental health care, soon to be replaced by another.

If one cares to take a close look at service users' accounts of recovery and the recovery literature generally, one discerns elements within that have lasting and educative value. The elements are there which could produce a significant shift of consciousness in ways of being with each other in the mental health context. The challenge is for all parties to listen and to relate to each other beyond the fears, attitudes and assumptions that can veil the reality of seeing each other as we really are and as the people we want to become.

Bibliography

Anthony W. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 01475622, April 1, **16**(4), 1-10. (Accessed online: <http://web.ebscohost.com/ehost/detail>)

Barker P. (2001) The Tidal Model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, **8**, 233-240

Clay, S. (1999) Madness and Reality. *From the Ashes of Experience: Reflections on madness, survival and growth*. Barker P, Campbell P, Davidson B (Eds.). London, Whurr Publications

Davenhill R. (2004) Old and new: Freud and others. *Talking Over the Years: A handbook of dynamic psychotherapy with older adults*. Evans S, Garner J (Eds.). Hove and New York, Brunner-Routledge

Davidson L, O'Connell M, Tondora J, Styron T, Kangas K. (2006) The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation. *Psychiatric Services*, *ps.psychiatryonline.org*, **57**(5), 640-645

Department of Health (2004) *The Ten Essential Shared Capabilities: A framework for the whole of the mental health workforce*. London, Department of Health

Forzisi L, Oduola S. (2007) Recovery in Mental Health: Evaluating staff training, 'Southwark and Lambeth Mental health teams project presentation'. (Unpublished)

Jacobson N, Greenley D. (2001) What is Recovery? A conceptual model and explication. *Psychiatric Services*, **52**, 482-485. (Accessed online: <http://ps.psychiatryonline.org/cgi/content/full>)

Lartey E. (1997) *In Living Colour: An intercultural approach to pastoral care and counselling*. London, Cassell

May R. (2007) Recovering Healing Communities. *Whose Recovery is it Anyway?* London, Social Perspectives Network

Macquarrie J. (1982) *In Search of Humanity: A theological and philosophical approach*. London, SCM Press Ltd

Moore T. (2004) *Dark nights of the soul: A guide to finding your way through life's ordeals*. New York, Gotham Books

National Institute for Mental Health in England (2005) *NIMHE Guiding Statement on Recovery*. London, Department of Health

Newell C. (2008) Brief Encounters in an Acute Mental Health Unit: A brief reflection. *Bishop John Robinson Fellowship Newsletter*, Issue 19

Rethink. (2003) *Self-Management: The experiences and views of self-management of people with a schizophrenia diagnosis*. Surrey, Rethink

South London and Maudsley NHS Foundation Trust Social *Inclusion, Rehabilitation and Recovery Strategy, 2007-2010*. London, SlaM

Wright S, Sayre-Adams J. (2000) *Sacred Space: Right relationship and spirituality in healthcare*. Edinburgh, Churchill Livingstone

Young S, Ensing D. (1999) Exploring Recovery from the Perspective of People with Psychiatric Disabilities. *Psychiatric Rehabilitation Journal*, **22**(3)

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