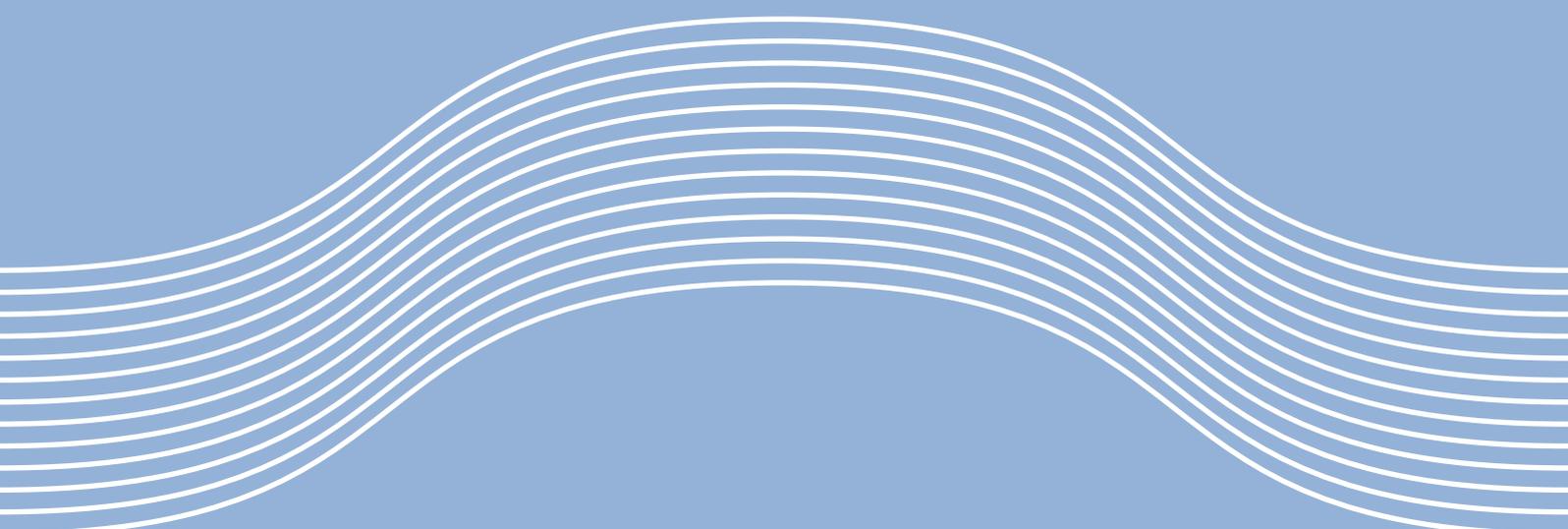


Recovery is for All

Hope, Agency and Opportunity in Psychiatry

A Position Statement by Consultant Psychiatrists



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South London and Maudsley NHS Foundation Trust

South West London and St George's Mental Health NHS Trust

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FOREWORD

Recovery focused services are a central component to making our mental health services fit for the twenty-first century. Whilst the concepts of Recovery is not new, as psychiatrists we need to rethink how we work alongside, in partnership with, people who use our services to enable them to get on with life from the point when they first access services.

As clinicians we are not abandoning our traditional medical skills of assessment, diagnosis and treatment. However, the challenge for us is to look beyond clinical recovery and to measure effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the individual service user and their family. We need to continually ask ourselves are we helping or hindering a person in their recovery.

A central tenant of NHS policy is showing us that a recovery focused approach, in particular shared decision making, needs to become the norm: *no decision about me without me*¹. Research shows us that shared decision making in mental health has the potential to improve mental health care as it impacts on quality of life, autonomy, choice and health outcomes.

Our primary interest should be to take the principles and concepts of Recovery and to look at ways in which our practices and all our services across both Trusts can be orientated to facilitate Recovery in people who use them.

This position statement is the result of joint working between our two mental health trusts. In particular, we are indebted to Dr Jed Boardman and Dr Mark Potter for leading this work across the two organisations. We believe *Recovery is for All: Hope, Agency and Opportunity in Psychiatry* provides the conceptual and practical framework for psychiatrists to turn the vision of recovery focused mental health services into reality. We wholly endorse the recommendations within this position statement and as medical directors will provide the leadership to implement recovery focused practice across psychiatry within our respective organisations.



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¹ Department of Health (2010) *Equity and Excellence: Liberating the NHS*. The Stationery Office, Norwich.

POSITION STATEMENT

BACKGROUND

This position statement was developed following a joint workshop on Recovery for consultant psychiatrists in two London NHS Trusts, the South West London and St George's Mental Health NHS Trust and the South London and Maudsley NHS Foundation Trust. A smaller group of consultants was given the task of developing a coherent view of Recovery and of summarising the key factors that support the relevance of Recovery principles for the practice of clinicians and the future development of mental health services. The group was comprised of clinicians from the major specialities of psychiatry: General Adult Psychiatry, Older Adults, Child and Adolescent, Forensic, Addictions and Learning Disabilities. The full document provides the detailed background to our deliberations, including sections on the incorporation of the principles of Recovery into the main psychiatric specialities. In this section we set out our core arguments as to the central importance of the principles and values of Recovery to the future practice of Psychiatry and how we would like to see these incorporated into the development of mental health services.

Integrating the ideas of Recovery into the practice of mental health professionals and into mental health services is a central component to making our services fit for the twenty-first century. As senior professionals in mental health services we believe that we should play a major part in leading this change and supporting the needs and wishes of service users to live a more fulfilling life.

WHAT IS RECOVERY?

A helpful and succinct definition is:

“... a deeply personal, unique process of changing one's attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.”
(Anthony, 1993).

There is no set model of Recovery and it is better to speak about Recovery ideas or concepts. This means that:

- Recovery is about individualised approaches and, as the definition suggests, it is about having a satisfying and fulfilling life, *as defined by each person*.
- Recovery does not necessarily mean 'clinical recovery' (usually defined in terms of symptoms and cure) - it does mean 'social recovery' – building a life beyond illness without necessarily achieving the elimination of the symptoms of illness.
- Recovery is often described as a journey, with its inevitable ups and downs, and people often describe themselves as being *in* Recovery rather than *Recovered*.

Recovery can be seen as a process and can be most helpfully defined by three core concepts:

- **Hope.** Hope is a central aspect of Recovery as Recovery is probably impossible without hope. It is essential to sustaining motivation and supporting expectations of an individually fulfilled life.
- **Agency.** This refers to people gaining a sense of control. Recovery means service users taking control over their own problems, the services they receive, and their lives. It is concerned with self-management, self-determination, choice and responsibility.
- **Opportunity.** This links Recovery with social inclusion and thus peoples' participation in a wider society. People with mental health problems wish to be part of communities; to be a valued member of and contribute to those communities; and have access to the opportunities that exist within those communities.

THE IMPORTANCE OF RECOVERY PRINCIPLES FOR PSYCHIATRY

The principles and values of Recovery ideas have been formulated by, and for, service users to describe their own experiences. It is service users that “do Recovery”. Professionals (and mental health services) can influence Recovery and Recovery journeys in that they can impede them, but they can also facilitate them. It is this idea of the facilitation of Recovery that must be central to the role of professionals.

It is clear that Recovery is not an intervention, it is not what professionals do to people. It is a description of the processes underlying the struggle of people with mental health problems to live meaningful and satisfying lives. Thus, for professionals, our primary interest should be to take the principles and concepts of Recovery and to look at ways in which our practices and services could be orientated to facilitate Recovery in the people who use them.

If Recovery ideas are to have an impact then professionals and others working in mental health services need to understand what Recovery means and, in partnership with service users and others, actively support their implementation across services.

This will mean a shift in the relationship between professionals and service users to one with a greater emphasis on partnership. It represents a transfer of the authority to define and recognise Recovery away from the professional to the individual.

The principles and values of Recovery overlap with other key concepts such as empowerment, self-management, disability rights, social inclusion and rehabilitation. As clinicians we should be concerned with how these concepts can steer the future direction of services.

Recovery can also be seen as a values-led approach which is focused on social and personally-valued outcomes. As such, it can provide an important orientation for practice, practitioners and services, and is consistent with the guiding values of all the healing professions. In this way it has clear relevance for psychiatry and psychiatric practice. Central to these values is the collaboration and partnership with many others within and beyond professional boundaries.

WHY SHOULD PSYCHIATRISTS SUPPORT THE IMPLEMENTATION OF RECOVERY PRINCIPLES?

The fundamental reason for supporting their implementation is because that is what service users want. This has the potential to provide them with an enhanced experience of mental health services, to improve the quality of those services and to improve the outcomes of people who use those services.

In addition, their implementation has the potential to improve the working lives of mental health professionals and the satisfaction they obtain from their daily work. The Recovery approach offers an exciting re-evaluation of practice for psychiatrists, allowing us to work in partnership with service users to improve their lives.

The challenge to mental health professionals is to look beyond clinical recovery and to measure effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the individual service user and their family, i.e. those of personal Recovery.

Other reasons for supporting the implementation of Recovery principles include:

- *Outcomes of severe mental illness* - The evidence about the prospects for people diagnosed with a severe mental illness is reasonably encouraging. Whilst clinical recovery is possible for people with schizophrenia, the evidence also points to the fact that people can also enter a process of personal Recovery beyond, and in the presence of, ongoing symptoms and difficulties.
- *Historical developments in mental health services* - In the United Kingdom over the past 60 years we have moved from an asylum-based system to one of community services. The first national plan and standards for adult mental health services (the National Service Framework) in England ended in 2009. This means that there is presently an opportunity to develop Recovery-orientated practice and services.
- *Policy developments* - Recovery ideas are now a core part of Department of Health Policy and are supported by other mental health professional bodies in the UK. The development in English national policy, *New Horizons* (HM Government, 2009), offered the opportunity to make Recovery-orientated practice the core of our mental health services. For the new government, the White paper, *Liberating the NHS*, with its clear focus on service user experience (quality) and shared decision making – *no decision about me without me* (Department of Health, 2010) there remains a central place in policy for Recovery-orientated practice. There is also international interest – and national plans relating to Recovery in several countries including New Zealand, USA, and Ireland.
- *Professional developments* - The profession of medicine is becoming more collaborative, with a greater emphasis on shared decision making, self-care and patient choice, and greater recognition of the contribution of service users as experts in their own conditions. Psychiatry is a core medical discipline.

- *Evidence for the benefits of working in a Recovery-orientated way* - There is evidence for the effectiveness of a number of specific interventions which most people agree would support a 'Recovery approach' and which can be examined in terms of their effectiveness in producing Recovery-relevant outcomes. Successful interventions which have particularly good evidence for their effectiveness include those that aim to improve employment outcomes and empowerment. To these we may add interventions involving Peer support and self management.

OPPORTUNITIES ASSOCIATED WITH RECOVERY-ORIENTATED PRACTICE AND SERVICES

The shift of to a greater collaborative clinical relationship between professionals and service users and the greater focus on personal Recovery provides opportunities that can bring future benefits to service users, professionals, families and carers. There are several ways in which this may be advantageous:

- *Personal Recovery places greater value on the personal knowledge of the individual.* This highlights the presence of two experts in the clinical encounter – the clinician with their technical knowledge and the service user with their expertise by experience; the value of both professional and personal knowledge. This may provide greater job satisfaction for professionals as well as improved engagement of service users in the management of their own problems.
- *Personal Recovery places greater emphasis on the personal priorities of the service user rather than on the professionally defined best interests of the service user.* For clinicians, this emphasises the values underpinning their work and helps them understand their role. For service users this may lead to better outcomes and is more likely to enable them to live the lives they want to lead.
- *The introduction of personal Recovery priorities provides a more balanced and evidence-based approach to treatment.* Our major treatments are not as effective as we often think and the limitations to our standard approaches can be supplemented by a Recovery-orientated practice.
- *Personal Recovery approaches can readdress the historically subordinate interests of people with mental illness in society.* It provides a means of empowering service users and reasserting their rights and citizenship with the potential of providing greater social inclusion and a potential role for clinicians in helping promote this.

CONCLUSIONS

We conclude that Recovery ideas should form the guiding principles to govern the future development of mental health services and that this has benefits for both service users and practitioners. There is a need to transform training and clinical practice, mental health services and culture to create practices and services that are Recovery-orientated and support service users in their Recovery journeys.

The key ideas of Recovery, *Hope, Agency and Opportunity* should run through mental health practice and services, providing the central ideas to guide the day to day practice of mental

health professionals and the organisation and culture of our mental health services. These ideas and values need to be translated into practice in order to guide the development of Recovery-orientated mental health services across all psychiatric specialities.

We believe that:

Recovery is probably the most important new direction for mental health services. It represents the convergence of a number of ideas (empowerment, self-management, disability rights, social inclusion and rehabilitation) under a single heading that signals a new direction for mental health services which is supported by service users, authoritative professional bodies, mental health policy and key leaders in mental health around the world.

- Recovery ideas should form the guiding principles to govern the future development of mental health services.
- Recovery ideas should provide the basis for the future direction of psychiatric practice and be applied across the major sub-specialities of psychiatry.
- The adoption of Recovery ideas by mental health services has profound advantages for service users and can improve the quality of mental health services, the experience of service users by expanding and improving the outcomes of for service users.
- The uptake of Recovery ideas has the potential to improve not only the practice of psychiatry but also the satisfaction and working lives of practitioners.
- Psychiatrists, in partnership with service users, other professionals and agencies, should take a leadership role in advocating for changes that address the limitations and barriers for people with mental health problems to live in hope, exercise greater choice and control and to have access to a greater range of opportunities to live a life that they value and choose.

We recommend:

- A greater emphasis be placed on Recovery, and its implications for practice, in the education and training of psychiatrists at the undergraduate and postgraduate levels and in our continuing professional development. This includes the development of the skills, knowledge and support to promote successful self-care, self-management and self-directed care.
- Changes to the practise of psychiatrists to give greater prominence to the principles of Recovery and to the development of an emphasis on partnership between doctor and service user.
- A Recovery-orientation be built into the annual appraisal process to stress the importance of changing practice in our professional development and to assess professional practice against the standards and values of a Recovery-orientated approach.

- The delivery of services which address not only the improvement of symptomatic outcomes for people, but also social outcomes. These should be given priority when commissioning specific services.
- The development of best practice guidelines that give priority to a range of approaches to support Recovery goals and planning that emphasises *hope, agency and opportunity*.
- The development of a culture throughout mental health provider and commissioning organisations in which Recovery principles are embedded and supported by, for example, managerial practices, risk policies, recruitment, training and service delivery.
- A change to the way in which service users participate in their own treatment and involvement in mental health services, which places greater emphasis on partnership and the active involvement of services in such roles as trainers and peer professionals.
- A review of the current mental health workforce which highlights the role of people with lived experience of mental health problems as peer specialists.

SUPPORTING RATIONALE AND EVIDENCE FOR THE IMPORTANCE OF RECOVERY

This section provides a longer discussion of the arguments and evidence for the importance of Recovery principles and values for the future development of mental health practice and services.

INTRODUCTION

This paper is concerned with the importance of the ideas and principles of Recovery for the future practice of psychiatry. It emphasises the need to examine how we might alter our practices and services to become 'Recovery-orientated'. We first cover the generic arguments for the importance of Recovery and then examine the implications for a range of sub-specialities: Forensic Psychiatry, Addictions, Older Adults, Child and Adolescent Psychiatry and Learning disabilities.

BACKGROUND

In 2009, the South West London and St George's Mental Health NHS Trust and the South London and Maudsley Mental Health Foundation Trust organised a joint workshop for Consultant Psychiatrists on Recovery. The workshop was set up to inform consultants about the latest thinking and practice associated with Recovery, to explore their views about the relevance of Recovery to clinical practice and to understand the role of psychiatrists in Recovery-orientated services. When setting up the workshop the Recovery Leads from both Trusts were aware of the strides already made in their own organisations in developing services that were consistent with the ideas of Recovery, but also the apparent scepticism, and sometimes cynicism, about the Recovery approach. However, it was clear to both Trusts that the ideas of Recovery have a central role to play in the future improvement of the quality of mental health services and that Consultant Psychiatrists must have a key leadership role in promoting these developments.

Over 60 consultants from a range of specialities attended and gave their views on the ideas of Recovery and the ways in which their clinical practice could incorporate these ideas. Whilst there was discussion and argument about how these ideas may be incorporated into clinical practice, a consensus emerged that Recovery orientated practice was important to the way professionals practice and the organisation of mental health services. It was clear that, not only could the orientation of mental health services and practice improve the quality of service user experience and outcomes, but that this could also improve the quality of the working lives of clinicians.

One outcome of the workshop was to direct a small group of consultants, from different psychiatric specialities, to produce a written statement outlining the importance of Recovery ideas for the future of practice and services and outlining some ways in which these may change. This Position Statement and its supporting rationale is the result of the group's attention to that task.

This section of the paper provides a background to the ideas and concepts of Recovery, a general consideration of its importance and the way they may be incorporated into mental health practice and services. In addition, the implications for some of the psychiatric sub-specialities are considered, including Child and Adolescent Psychiatry, Older Adults, Forensic Psychiatry, Addictions and Learning Disabilities.

WHAT IS RECOVERY?

Recovery is probably the most important new direction for mental health services. It represents the convergence of a number of ideas – empowerment, self-management, disability rights, social inclusion and rehabilitation - under a single heading that signals a new direction for mental health services which is supported by service users, authoritative sources, English mental health policy and key leaders in mental health around the world.

Much has been written on this subject, and there are many definitions of Recovery, but one succinct definition has been formulated by Anthony (1993):

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

This definition highlights the fact that Recovery is about having a satisfying and fulfilling life, *as defined by each person* (Slade 2009, Repper & Perkins, 2003). It represents a shift in who has authority to define and recognise Recovery away from the professional and to the individual.

Whilst some people refer to a ‘Recovery model’, it is probably better to speak about Recovery ideas or concepts. A model would suggest that there is a Recovery manual somewhere that should be applied to all people to fix them and the opposite is in fact true. Recovery is about individualised approaches.

It is clear from this that Recovery does not necessarily mean ‘clinical recovery’ which is usually defined in terms of symptoms and cure. Rather, it means ‘social recovery’; building a life beyond illness without necessarily achieving the elimination of symptoms of illness. This concept of Recovery can also be applied to people with long-term conditions or disabilities, for example, diabetes, asthma, arthritis. People often describe Recovery as a journey; it may have ups and downs. A period of illness does not necessarily mean that Recovery stops, it may in fact be part of the longer term process of learning and developing an understanding of the illness. Some people, particularly those who experience long term problems say that Recovery is about regaining control and for some it means Recovery from the impact of an illness. People often describe themselves as being *in* Recovery rather than *Recovered*. This is a fundamentally different understanding of what Recovery means from the traditional clinical sense of Recovery as measured and evaluated by the clinician. Input from mental health services is just part of Recovery journey. Recovery as discussed here can mean both recovery from the condition and recovery of a life worth living. These can be both independent and interdependent.

Recovery can be seen as a process, the components of which include: finding and maintaining hope, re-establishing a positive identity, building a meaningful life, and taking responsibility and control (Andresen et al, 2006). Some suggested principles of Recovery are shown in *Box 1*. This may be boiled down to three core concepts that define Recovery: *Hope, Agency and Opportunity*.

Hope

Hope is a central aspect of Recovery and some would say that Recovery is impossible without hope. It is central to sustaining motivation and supporting expectations of an individually fulfilled life - if you can't see the possibility of a decent future for yourself then what is the point in trying? Relationships are central to hope, as we all know that it is difficult to believe in yourself if everyone around you thinks you will never amount to very much, and when you find it hard to believe in yourself, you need others to believe in you

Agency

This refers to people gaining a sense of control. In this sense Recovery involves service users taking control over their own problems, the services they receive, their life and destiny. For example, control over the way they understand what has happened to them, their problems and the help they receive, what they do in their lives and their dreams and ambitions. Recovery is concerned with self-management, self-determination, choice and responsibility.

Opportunity

The idea of opportunity links us with the idea of social inclusion and is concerned with participation in a wider society. Social inclusion is important for Recovery as people with mental health problems wish to be part of communities, not apart from them. They wish to be a valued member of those communities, to have access to the opportunities that exist in those communities, and to have the opportunity to contribute to those communities.

Recovery can also be seen as a values-led approach focused on social and personally-valued outcomes. In this way it offers hope or goals for people and an orientation for practice, practitioners and services. An approach based on the values of Recovery overlaps significantly with the guiding values of all the healing professions and in this way has clear relevance for psychiatry and psychiatric practice. Central to these values are collaboration and partnership with many others within, and beyond, professional boundaries.

BOX 1. THE PRINCIPLES OF RECOVERY

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

Sources: Shepherd, G., Boardman, J., & Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health. (Adapted from Recovery – Concepts and Application by Laurie Davidson, the Devon Recovery Group).

IS RECOVERY POSSIBLE?

Why should we believe that Recovery is possible? The *evidence* about the prospects for people diagnosed with a severe mental illness is reasonably encouraging. Almost half can realistically look forward to 'clinical recovery' and less than a quarter are likely to remain severely socially disabled. The empirical evidence comes from studies examining the long-term outcomes of people with schizophrenia. A meta-analysis of over 100 studies revealed that more than 20% of participants showed complete social recovery following a first psychotic episode (economic and residential independence and low social disruption) and a further 20% showed partial recovery (Warner, 2004). When international studies are added, particularly from India and Hong Kong, a similar pattern is seen, with outcomes being particularly favourable in the developing world (Warner, 2009).

Here it is clear that clinical recovery is possible for people with schizophrenia. We may undervalue clinical recovery even if the evidence for this is more favourable than we often believe. However, this evidence also points to the fact that people can also enter a process of personal Recovery beyond that and in the presence of ongoing symptoms and difficulties.

WHY SHOULD WE BE INTERESTED IN RECOVERY?

Psychiatrists and others working in mental health services do not 'do' Recovery. Recovery is what service users 'do'. As psychiatrists we should be concerned with how we can facilitate Recovery or, at least, not hinder it. Nevertheless, if Recovery ideas are to have an impact then professionals and others working in mental health services need to understand what Recovery means and, in partnership with service users and others, actively support its implementation across services. This will require us to think about changing the way we work; about changing the structure and organisation of our services; and about changing the culture of our organisations in order to make our services more 'Recovery-orientated'. Recovery ideas and Recovery-orientated practice has the potential to radically transform mental health services for the better and to alter traditional power relationships.

Historical developments mean that there is presently an opportunity to develop Recovery-orientated services. In the United Kingdom over the past 60 years we have moved from an asylum-based system to one of community services. The first national plan and standards for adult mental health services (the National Service Framework) in England ended in 2009. This means that there is presently an opportunity to develop Recovery-orientated practice and services.

Recovery ideas are now a core part of Department of Health Policy and are supported by other mental health professional bodies in the UK. The development in English national policy, *New Horizons* (HM Government, 2009), offered the opportunity to make Recovery-orientated practice the core of our mental health services. For the new government, the White paper, *Liberating the NHS*, with its clear focus on service user experience (quality) and shared decision making – *no decision about me without me* (Department of Health, 2010) there remains a central place in policy for Recovery-orientated practice. There is also international interest – and national plans relating to Recovery in several countries including New Zealand, USA, and Ireland.

In addition, the profession of medicine is changing. It is becoming more collaborative, with a greater emphasis on shared decision making, self-care and patient choice, and greater recognition of the contribution of service users as experts in their own conditions. Psychiatry may be ahead of this trend, but should be careful not get left behind.

The challenge to mental health professionals is, therefore, to look beyond clinical recovery and to measure effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the individual service user and their family, i.e. personal Recovery (Craig, 2008).

BENEFITS OF RECOVERY

We are clear that Recovery is not an intervention. It is not what professionals do to people, but rather it is a description of processes underlying the struggle of people with mental health problems to live meaningful and satisfying lives.

It would thus be unhelpful to ask the question, *does Recovery work?* However, we can examine the possible benefits of working in a Recovery-orientated way. In addition, on the basis of the literature, we can try to specify a set of conditions within mental health services that will make 'Recovery' more likely and can therefore examine the effectiveness of a number of specific interventions which most people agree would support a 'Recovery approach'. In this way we can examine them in terms of their effectiveness in producing Recovery-relevant outcomes.

For example, in adults of working age, two areas have particularly good evidence for their effectiveness: improving employment outcomes and empowerment (Warner, 2009). To these we may add interventions involving intentional peer support and self management.

Improving employment outcomes

There is strong evidence, from random-controlled trials undertaken in several different countries, for the effectiveness of 'Individual Placement and Support' ('IPS'), a specific approach to vocational rehabilitation. IPS has been shown to achieve employment rates 2-3 times better than traditional alternatives such as interview training and sheltered workshops. More than half of those receiving IPS achieved successful placement in paid employment, compared with only 20-25% of controls. Those supported by IPS worked significantly more hours, had higher earnings and better job tenure. The higher rates of employment resulting from IPS also have positive long-term benefits in terms of improved confidence and wellbeing and reduced reliance on mental health services (Sainsbury Centre for Mental Health, 2009a).

Empowerment

One means of empowerment is through the involvement of service users in key decisions regarding their treatment and management. There is extensive evidence that a reduced sense of empowerment is associated with lower self-esteem, higher sense of stigma, poorer quality of life and a range of negative outcomes (Warner, 2009). Evidence in this area comes from three approaches. First, the *shared decision making* model for medication management developed by Deegan & Drake (2006). Research shows us that shared decision making in mental health has the potential to improve mental health care as it impacts on quality of life, autonomy, choice and health outcomes (Simon *et al.*, 2009). Another approach is through the use of *Joint Crisis Plans* (JCP), sometimes known as advance directives, to cover arrangements for admission to hospital which can reduce involuntary admissions and improve service users sense of control of their mental health problems (Henderson *et al.*, 2004; 2008). Finally, the use of an educational approach (rather than a therapeutic approach) to *illness-management and Recovery*, is designed to provide people with severe mental illness with the information and skills necessary to manage their illness effectively and work towards achieving personal Recovery goals (Mueser *et al.*, 2002). The benefits for service users include an increased their knowledge of illness, coping skills, personal goal identification and attainment.

Peer support

This concerns the use of others with lived experience of mental health problems acting as workers who directly help others with similar problems. There are now a number of trials and studies of peer support interventions (Chinman *et al.*, 2008) which show that appropriately trained and supported peers can increase service users' satisfaction; their sense of control (self-efficacy), empowerment and movement towards Recovery. They can also help the person expand their social networks, gain hope and become more involved in their own care. Evidence shows that peer support specialists working within mental health services and alongside professionals can reduce length of hospital admissions and support earlier discharge (Slade, 2009).

Self management

Through an educational approach service users can learn more about their conditions and make supported decisions based on this learning. Self management aims to enable people to develop practical tools of everyday living in order for them to make daily decisions that will maintain or improve their health. Self management has developed from supporting people who have long term health conditions and has begun to be applied to people who experience mental health conditions. Two streams of mental health self management have developed, condition specific self management (Rinaldi, 2002) and generic self management (Lawn *et al.*, 2007; Cook *et al.*, 2009). Evaluation of this work is still in its infancy and there remains a need for more systematic research in this area.

THE OPPORTUNITIES ASSOCIATED WITH RECOVERY-ORIENTATED PRACTICE AND SERVICES

There does seem to be evidence for benefits that are associated with some aspects of Recovery-orientated practice. But there are other opportunities associated with this approach that can bring future benefits to service users, professionals, families and carers. These are mainly associated with shifting the clinical relationship between professionals and service users to make it more collaborative and by focusing more on personal Recovery.

There are several ways in which this may be advantageous (Slade, 2009):

1. Personal Recovery places greater value on the personal knowledge of the individual. There are two experts in the encounter between clinicians and service users – the clinician with their technical knowledge and the service user with their expertise by experience. These two experts should work in partnership and value both professional and personal knowledge. This encourages clinicians to work in a different way and can result in greater job satisfaction for professionals as well as improved engagement of service users in the management of their own problems.
2. Personal Recovery places greater emphasis on the personal priorities of the service user than on the professionally defined best interests of the individual. For clinicians, this helps in being clearer about the need to place emphasis on the values underpinning the application of rational scientific knowledge, and enhances the understanding of their roles. For service users the delivery of care which uses socially inclusive and Recovery orientated approaches in line with their preferences and choice, is likely to lead to better outcomes as we saw above. Working with service users' preferences and choices as far as possible, is more likely to enable them to live the lives they want to lead.

3. Our major treatments are not as effective as we often think. The introduction of personal Recovery priorities provides a more balanced and evidence-based approach to treatment. We have some evidence for drugs, psychotherapeutic approaches and types of services which have benefits for clinical outcomes, but this evidence shows the limitations to these approaches and they need to be supplemented by additional efforts. Recovery-orientated practice can help to supplement our usual approaches. Valuing of social outcomes and ways of achieving these can improve the outcomes for service users especially when they may need to learn to live with continuing symptoms and fluctuating conditions.
4. Historically, the interests of people with mental illness in society have been subordinate, with resultant personal and collective harm to them. Personal Recovery readdresses this and provides a means of empowering service users and reasserting their rights and citizenship. The benefits here of their greater social inclusion for service users and the role of clinicians in helping promote this. This means attending to the rights of people with mental ill-health, to citizenship, equality and justice, and stigma and discrimination, and to the status of people with mental health problems in society.

The Recovery approach represents a paradigm shift in the relationship between the individual and psychiatrist. Current practice focuses on evidence based medicine, encouraged by professional groups and health provider organisations. However, although this is vital to providing high quality patient care, it is led by professionals. A Recovery approach will allow a more equal dialogue between professionals and service users and perhaps offer more innovative care. The shift that is required is one from professionals doing things 'to' people to supporting them to 'do' things for themselves, how they like and in their own way. Thus, rather than being the subject of treatment, the person would become the object in directing their own life, albeit with treatment and support. This represents a shift from being 'patient' to being active, and from being seen as the source of problems to becoming the source for solutions. This shift places a central emphasis on education.

There is evidence for the efficacy of service user led Recovery particularly in the field of self help and user led groups. Organisations such as Alcoholics Anonymous have comparable outcomes to professionally led services (Project Match Research Group, 1997).

OBSTACLES TO RECOVERY-ORIENTATED PRACTICE

There are some often repeated arguments against a Recovery-orientated practice (Davidson et al, 2006; Shepherd et al, 2008) which may reflect criticisms based on an anxiety about new approaches and of change. There may also be a lack of knowledge about the evidence behind a Recovery approach, for example a recent survey of junior psychiatrists shows they tend to be rather paternalistic and pessimistic about the prospective of Recovery for people diagnosed with schizophrenia (Ng et al, 2008) despite the research evidence which shows that Recovery from schizophrenia is possible (Warner, 2009, 2010).

Some of these arguments are:

There is nothing new in the idea we have been doing it for years

To some degree the ideas of Recovery are not new, but they have not been driving our practice; much of what we do and the institutional design of services, often hinders Recovery and does not give adequate opportunity for service users voices to be heard. Recovery is sufficiently distinctive to justify its inclusion as a new concept and to explore its implications.

Recovery adds to the burden of the professional

If Recovery ideas replace the existing traditional ‘assessment-treatment-cure’ ideologies in mental health services then it may not add to the burden of professionals. There is however, an obvious danger of adding to staff workloads if Recovery-oriented care were simply to be ‘added on’. If Recovery ideas are integrated, the assessment process would focus more on things the service user wants to achieve. Interventions would be collaboratively agreed and would target these goals. Successful attainment of the goals would replace ‘cure’, though, in practice this might well be the same thing. This is a reworking of what staff do rather than an add-on or complete replacement and may eliminate unnecessary tasks and assist in achieving greater job satisfaction.

Recovery means the person is cured

Recovery is about the person and their life, what happens to their ‘illness’ is a different question. ‘Cure’ and ‘Recovery’ are not the same thing, but active treatment can play a role in the Recovery process. Treatment and gaining an understanding of oneself and one’s illness go hand-in-hand with Recovery. ‘Insight’ is less important than how the person evaluates different aspects of their life.

Recovery means the introduction of new services

A Recovery-orientation may not need a widescale introduction of new services. What is required is an adjustment of our approaches to re-emphasise the priorities of service users. We need to make existing services work more effectively, more directly driven by the needs of those who use them and with a clear Recovery-orientation. It may appear that key factors in a service user’s Recovery are outside the scope of traditional psychiatric care, though this should not negate the benefits of a Recovery-orientated approach which engenders hope and promotes control.

Recovery services are neither cost-effective nor evidence based

As we have indicated, evidence does exist to support the introduction of Recovery ideas. Here we need to consider a range of evidence, from first person accounts to randomised controlled trials. First person accounts have immediate validity, but controlled trial evidence, for example on the effectiveness of models for the communication of information about schizophrenia, approaches to the self-management of symptoms, effective help for families and friends, effective approaches for gaining and retaining open employment, may all be used to support people in their Recovery journeys. In addition, there are both health and social benefits. Feeling more ‘in control’ of one’s life and finding a meaning beyond illness are outcomes with important health consequences (Wagner et al, 2001).

Recovery approaches devalue the role of the professional

Professional input remains important but a Recovery-orientation places it in a different context. Professionals bring important expertise to the process of Recovery - expertise regarding effective treatment interventions, the functioning of groups, issues of engagement and conceptual frameworks to assist with the development of services and systems. In this context professionals do not stop being 'professional'. Professionals will remain a key source of advice and support for service users and may be the most important '*holders of hope*'. In Recovery-oriented services, professional expertise and authority is not given automatic primacy over the views of service users (or families and/or carers). Instead, they enter a dialogue in which their contribution is placed within the context of negotiated agreements about care. In general, people with long-term conditions do better when offered interventions that help to develop their skills, knowledge and confidence to actively participate in managing their illnesses over time (Wagner et al, 2001).

Recovery increases providers exposure to risk and liability

Risk is inherent in all mental health services and in Recovery-oriented services risk will remain. However it is sometimes necessary to take risks in order to learn and grow. A Recovery-orientated service will require a change in our emphasis from risk avoidance to constructive and creative risk taking. We must seek to differentiate between the risks that must be minimised (self-harm, harm to others) and the risks which people have a right to experience. Recovery ideas do swing the pendulum a bit more towards the latter, encouraging opportunities for growth and change (the '*dignity of risk*') but, of course, this must be done in a responsible way. The majority of risk is actually shared and the different stakeholders therefore have to be clear about what risk they are actually carrying. The skill then is of being risk aware but focused on safety planning in an increasingly collaborative approach that promotes people taking responsibility themselves for ensuring their safety with service supports. If an individual chooses to ignore clearly documented professional advice then they carry the risk; if a professional commits an act which clearly contradicts their '*duty of care*', then they are responsible. Either way, the risk is not being appropriately managed and it is certainly not helpful if professionals think that they carry the sole responsibility for how people live their lives.

CHANGING OUR APPROACHES: PRACTICE, SERVICES AND ORGANISATIONAL CULTURE

Three areas need to change in order to put Recovery ideas into practice: the way we practice, the organisation of our mental health services and the culture of our mental health services.

Role of professionals

Psychiatrists have always placed emphasis on the importance of the '*doctor-patient*' relationship and have harnessed this important dynamic in the healing process. They possess what might be called '*basic*' therapeutic skills, including empathy, acceptance and mutual affirmation and are also sensitive human beings who may sometimes need to use their life experiences to inform their work. They therefore have a wide range of skills, significantly beyond the delivery of a narrow, '*bio-medical*' model. Working in a Recovery-orientated way does not mean we need to abandon our traditional medical skills of assessment, diagnosis and treatment, but some of us do need to develop a more Recovery-orientated approach to our practice. This change of emphasis puts these traditional skills in

the service of supporting people in their Recovery and directed towards achieving goals valued by them. Our knowledge of medicine can also come into play as we know that people with mental health problems often receive sub-optimal physical health care and their experience of well-being is poor.

The fundamental change has to be with the quality of the partnership in which the psychiatrist operates in a different role and behaves more like a personal coach: “...*offering professional skills and knowledge, while learning from and valuing the patient, who is an ‘expert by experience’*” (Roberts & Wolfson, 2004, page 41). Coaching has a future focus, thinking of the person in terms of future potential and not their past. This is a shift from a professional who is seen as remote and in a position of expertise and ‘authority’. To facilitate this shift we may consider there to be two ‘experts’ in the consulting room: the medical expert who offers professional skills and knowledge, while learning from, and valuing, the service user (the ‘expert by experience’). As a coach, we may aim to provide the service user with resources (information, skills, networks, and support) to manage their own condition as far as possible and help them get access to resources they need to live their lives.

During our training we develop a range of therapeutic skills and, for a Recovery-orientated approach, these may be formulated in terms of the ability to work with the service user and significant others to formulate a shared understanding of the problem and a positive, forward-looking plan, which is implemented with clear, structured feedback regarding progress.

One example is when discussing diagnosis. Psychiatrists are often in the position of informing service users of their psychiatric diagnosis and in turn service users are on the receiving end of this news. For some, receiving a diagnosis can be helpful – it can serve to enable service users and their families to gain a better understanding of their condition and begin to make sense of the symptoms they are experiencing. For others, receiving a diagnosis can be perceived as receiving bad news or a cause uncertainty where a diagnosis is changed. Faulkner (1998) has defined bad news that healthcare professionals deliver as *‘information that could radically change the life of the recipient’*.

Psychiatrists may have valid reasons for not talking about potentially stigmatising diagnostic labels but these reasons have to be balanced against the benefits of the individuals increased understanding of their symptoms and condition, the ability for both to participate in shared decision making about treatment options, interventions that may be helpful with getting on with life and in planning for the future. Service users expect us as psychiatrists to provide information about their conditions, including the actual diagnosis. The failure to provide clear information, even if the service user or carer will be distressed by it or not understand the consequences, may ultimately heighten anxieties and minimise opportunities for their Recovery.

There is limited research on delivering difficult or bad news in psychiatry, but we may be able to learn from our Oncology colleagues (Cleary et al, 2009). Baile et al (2000) have developed a practical six step protocol (SPIKES) for delivering bad news to cancer patients which can be used across different medical settings including psychiatry. The overarching aims of the protocol are fourfold: to determine the service user’s understanding and

expectations; to give relevant information in a manner appropriate for that person; to provide support to the service user in order to reduce the negative emotional consequences of the news; and to collaborate in the development of a treatment plan.

Box 2 illustrates an adaptation of the SPIKES protocol for delivering bad news for psychiatrists and other mental health professionals.

BOX 2: PROTOCOL FOR BREAKING BAD NEWS

SPIKES: A Six-Step Protocol for Breaking Bad News

SPIKES	Dos	Don'ts
<p>Setting</p> 	<p>Establish the right Setting: Allocate adequate time for the encounter. Ensure service user privacy. Agenda set with the service user.</p>	<p>Interruptions</p>
<p>Perception</p> 	<p>Find out what the service user's Perception and understanding of his or her problem is. Pay attention to the service user's words. Make a mental note of the discrepancies between medical facts and service user's perspective.</p>	<p>Assumptions</p>
<p>Invitation</p> 	<p>Obtain a clear Invitation by the service user to give the information: "Are you the sort of person who wants all the details on their problem?"</p>	<p>Blunt disclosure</p>
<p>Knowledge</p> 	<p>Use the service user's current understanding of his or her problem as a starting point to provide Knowledge and medical facts. Use the same level of language as the service user uses and work with their frame of reference (Perception) for how they attribute and make sense of their problems (e.g. social, biological, trauma, spiritual etc). Give the information in small chunks. Check for service user understanding at each step.</p>	<p>Medical jargon</p>
<p>Empathy</p> 	<p>Be Empathic: "This must be very hard for you." Recognise that crying and anger are normal responses when receiving bad news. Provide realistic hope: "People can and do live meaningful, valued satisfying lives with the condition."</p>	<p>Destroy hope</p>
<p>Strategy</p>	<p>Explain your treatment Strategy and discuss self management strategies. Encourage the service user's participation in decision-making. Summarise main points; answer questions. Negotiate next contact. Remember receiving bad news often provokes an emotional response. Help the service user to process the information both emotionally and cognitively. You may need to recap and explore the service user's Perception at the next contact.</p>	<p>Ignore service user input</p>

Adapted by Rinaldi & Potter from Baile, et al. (2000). SPIKES--A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer. *Oncologist*, 5(4), 302-311.

In addition, the list of *10 Shared Capabilities* for inclusive practice may be helpful for psychiatrists (NIMHE, 2004; Department of Health, 2007a). These capabilities underpin the ‘*New Ways of Working*’ initiative, and include: working in partnership, respecting diversity, challenging inequality, identifying individual needs and strengths, promoting safety, and responsible risk-taking (Department of Health, 2007b). We will also need to adopt practical ways of conducting service user centred interactions and utilise useful pointers such as the Sainsbury Centre’s *10 top tips for Recovery-oriented practice* (Box 3).

These overlap with the key competencies and emphasise the importance of prioritising the service users goals wherever possible and demonstrating a belief that they can be achieved (‘maintaining hope and optimism’). Additionally, Recovery-oriented approaches also use a combination of professional help, self-help and non-mental health resources (such as friends, families, employers, education bodies) to enable the service user achieve their goals. We may need to turn traditional priorities upside down and set our sights away from cure, to being able to lead an ordinary life.

Box 3: TEN TOP TIPS FOR RECOVERY-ORIENTATED PRACTICE

A. Understand Recovery

1. Help the person identify and prioritise their personal goals for Recovery (not the professional’s goals)
2. Demonstrate a belief in the person’s existing strengths in relation to the pursuit of these goals.
3. Be able to identify examples from your own lived experience, or that of other service users, which inspires and validates hope.
4. Accept that the future is uncertain and that setbacks will occur, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations.

B. Know how to collaborate

5. Encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies etc.).
6. Listen to what the person wants in terms of therapeutic interventions, e.g. psychosocial treatments, alternative therapies, joint crisis planning etc. Show that you have listened.
7. Behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together.
8. Indicate a willingness to ‘go the extra mile’ to help the person achieve their goals.

C. Have a broad view

9. Pay particular attention to the importance of goals which take the person out of the traditional sick role and enable them to serve and help others.
10. Identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of these goals.

Source: Shepherd, G., Boardman, J., & Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Service changes

Recovery-orientated mental health services must be well organised services that deliver evidence based treatments that meet the needs of service users. They must also facilitate individual Recovery and the range of outcomes valued by service users: the normal social outcomes of something to do, somewhere to live and someone to love, and also their valued health outcomes (Charles Fraser quoted in Dunn, 1999, page viii). They should be designed to achieve both health and social outcomes in partnership with service users.

Personalisation within health and social care services represents a significant change in how services need to operate. Personalisation means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. One means of achieving this is through a Personal Budget where a person with a mental health problem can use an allocation of money to design and purchase support to meet their social care needs. Emerging evidence shows that people with mental health problems may have the most to gain from increased choice and control over their support arrangements (Glendinning et al, 2008). The piloting of Personal Health Budgets began in mid 2009. A Personal Health Budget helps service users to get the services they need to achieve their desired health outcomes. Service users with a Personal Health Budget are told how much money they have available for their care and support. They are then given help and support to use this money to buy services that best meet their needs. Service users are able to take as much control over the way in which this money is spent as is appropriate for them. There are currently 21 sites piloting personal health budgets for people with mental health problems.

The multidisciplinary team approach forms the bedrock of modern, adult mental health services. One of the key rationales for teams is that they can provide access to the range of specialist skills and expertise necessary to provide a more complete assessment of needs and a comprehensive plan of treatment and management for people with multiple and complex problems. From a Recovery-orientated perspective, these teams should contain the complete range of necessary skills covering all the areas that are likely to have an effect on illness and outcomes include finances, housing, employment, and social integration. We should also try to ensure that service users and their families and/or carers are included as part of this team viewing the establishment of these collaborative partnerships as central to the role of modern professionals. There should be a range of workers within the teams encompassing welfare advisors, employment specialists, housing and resettlement officers, as well as a significant number of mental health workers who have had experience of mental ill-health to act as Peer Professionals (Ashcraft and Anthony, 2005; Rinaldi 2009). This transformation of the current workforce is a key challenge to the provision of Recovery-orientated services (Sainsbury Centre for Mental Health, 2009b).

We should be particularly concerned to use evidence-based interventions that improve both clinical outcomes and social outcomes, such as family interventions for conduct disorder and related behavioural disorders in children, early intervention in first episode psychosis, supported employment for people with schizophrenia, and contingency management in addictions.

Professionals also have a key role in addressing stigmatising attitudes, which are usually based on a mixture of ignorance, prejudice and behavioural discrimination. For example, by contributing to staff education (addressing ignorance), facilitating direct face-to-face meetings between service users and staff in these agencies who hold these attitudes (addressing prejudice), and identifying illegal discriminatory behaviour. Doctors continue to be held in high esteem by the general public and putting their weight behind these kinds of initiatives at a local level can be extremely powerful.

Organisational culture

Ten key organisational challenges for mental health services in England to deliver Recovery-orientated services have been developed (Sainsbury Centre for Mental Health, 2009) and are summarised in *Box 4*.

BOX 4: MAKING ORGANISATIONS MORE RECOVERY-ORIENTATED

TEN KEY ORGANISATIONAL CHALLENGES

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, service user-led education and training programmes
3. Establishing a 'Recovery Education Centre' to drive the programmes forward
4. Ensuring organisational commitment, creating the 'culture'
5. Increasing 'personalisation' and choice
6. Changing the way we approach risk assessment and management
7. Redefining service user involvement
8. Transforming the workforce
9. Supporting staff in their Recovery journey
10. Increasing opportunities for building a life 'beyond illness'.

Source: Sainsbury Centre for Mental Health (2009) *Implementing Recovery. A new framework for organisational change*. Position Paper. London: Sainsbury Centre for Mental Health.

A Recovery-orientated culture needs to run through our mental health services and Recovery values need to become embedded in every management process in the organisation including recruitment, supervision, appraisal, audit, planning and operational policies. These values also need to be reflected in the publicly stated principles and values of the organisation. This requires leadership from the top (Board level) as well as commitment from the middle levels of management and practitioners at the front line. Outcomes for the organisation should be based on Recovery-oriented goals. These necessary changes need to be understood by commissioners of services and commissioned through co-production between the commissioners and the local service providers (Shepherd et al, 2010).

This culture must value the input of service users, families and carers, and redefine service user involvement to create a more equal partnership. Involvement of service users, families and carers should not only be in the planning of their own care but also in the planning of services and an active participation in research. Service users are central to providing training for staff and peer professionals can act a 'champions for change'.

Risk policies must change to support positive risk taking and an emphasis on managing risk when this involves ordinary risk taking, such as letting people have control of their finances or whether or not they go to work. Whilst we need to continue to do careful risk assessments and, at times, intervene when we think the person themselves or others are at serious risk of harm, we should support people to take risks which may enhance their personal Recovery. Human resource strategies must change to open up further job opportunities in the workforce for people who have experienced mental ill-health.

Recovery-oriented services must have strong strategic relationships with the necessary range of social care agencies, for example housing, employment and community networks. These strategic alliances must be based not just on good working relationships between individual practitioners, but also mutually agreed strategic plans which recognise the contribution of each agency working together. Such 'partnership agreements' need clear, realistic goals, transparent commitment of resources and agreed methods for monitoring progress so that both sides can be satisfied that the partnership is working effectively.

Overall, the Recovery approach offers an exciting re-evaluation of practice for psychiatrists, allowing us to work in partnership with service users to improve lives (Roberts and Hollins, 2007).

RECOVERY AND THE MAIN PSYCHIATRIC SUB-SPECIALITIES

The arguments put forward above to support the importance of Recovery and its ideas to psychiatry have been largely generic and have been mainly applied to adults of working age. However, we believe that the ideas and principles of Recovery apply across all the mental health specialities, although they may need to be adapted and applied in different ways to suit each of these areas. In this appendix we have included sections examining the application of Recovery to the main sub-specialities of the psychiatry of Older Adults, Children and Adolescents, Addictions, Forensic Psychiatry and Learning Disabilities.

OLDER ADULTS

RECOVERY INCLUDES MENTAL HEALTH OF OLDER PEOPLE

The importance of helping people with mental health problems and their families, carers and friends to retain and recover meaning and purpose in life is not restricted to ‘adults of working age’ who have functional mental health problems. The central concepts of Recovery (hope, agency and opportunity) apply as much to Older People’s Mental Health Services as they do to working age adults. Old Age Psychiatrists, especially in Multi Disciplinary Teams, are prey to an extreme form of Physician’s Negative Bias – we often complain that we develop large caseloads of the ‘unrecovered and incurable’ and have developed cynicism and experienced a loss of hope over the years.

The emerging literature on Recovery in Older People’s Mental Health Services has been reviewed by Hill et al (2010) where they explored in some detail the similar but parallel paths of development of Recovery in Rehabilitation services and Person Centred Care in the care of people with dementia (see table 1). They note the shared origins from the work of Tuke in the 18th century and Rogers in the 20th century concerning identity and personhood and re-emphasise the importance of relationships and social context. Many Old Age Psychiatrists have rightly been sceptical about the use of the term Recovery in the management of people with Dementia, indeed the word may need to be used with caution in this context. However, several commentators have noted the similarity between the principles of Recovery and Tom Kitwood’s work on Dementia Care Mapping (Kitwood, 1997). Hill and colleagues explore social engagement and avoidance of segregation, both important factors in improving social inclusion and made clear links between the work of Goffman (1974) and Kitwood (1997). The development of assisted housing schemes which enable people with dementia to live independently with assistive technology and community support are important service developments. The changing role of professionals to that of ‘mentor, coach, support, advocate and ambassador’ is encouraged, as are changes in the involvement and support offered to families and informal carers. The use of tools to encourage the development of care plans that are meaningful to and owned by service users and their families is important.

The implications of the values implicit in an approach based on the principles of Recovery are profound and the challenge to implement them successfully is significant both for professionals and for society at large. Some of the principles have already been embodied in Government Policy and there have been international developments. *‘Everybody’s Business’* (Care Services Improvement Partnership, 2005). This guide to the development of integrated mental health services for older people - stresses the importance of respect and

dignity and the principles that must underlie services: a person-centred approach, improving quality of life, meeting complex needs in a co-ordinated way and promoting age equality.

“Staying mentally and physically active gives a sense of purpose and personal worth to people, as well as enabling people to make an effective contribution to their communities. Participating in valued activities can also provide an opportunity for social contact. Hobbies and leisure activities, lifelong learning, as well as volunteering, employment, and engagement in the development or delivery of local services should all be supported.” (Everybody’s Business, page 13)

Overall, there is a need to look at ‘whole systems’ change. Despite the continued debate about the semantics of the word Recovery a ‘curious convergence’ between the principals of Recovery and Person Centred Care can be identified (Table 1).

TABLE 1: COMPARABLE PRINCIPLES IN RECOVERY-ORIENTATED PRACTICE AND PERSON-CENTRED CARE

Recovery (CSIP, RCPsych & SCIE, 2007; Sainsbury Centre for Mental Health, 2008)	Person-Centred Care (Kitwood, 1997, McCormack, 2004; Brooker, 2007)
Recovery is fundamentally about a set of values related to human living applied to the pursuit of health and wellness	A value base that asserts the absolute value of all human lives regardless of age or cognitive ability
The helping relationship between clinicians and patients moves away from being expert/patient to being ‘coaches’ or ‘partners’ on a journey of discovery	The need to move beyond a focus on technical competence and to engage in authentic humanistic caring practices that embrace all forms of knowing and acting, in order to promote choice and partnership in care decision-making
Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying roles in society	People with dementia need an enriched environment which both compensates for their impairment and fosters opportunities for personal growth
People do not recover in isolation. Family and other supporters are often crucial to Recovery and should be included as partners wherever possible	Recognises that all human life, including that of people with dementia, is grounded in relationships
Recovery approaches give positive value to cultural, religious, sexual and other forms of diversity as resources and supports for wellbeing and identity	An individualised approach – valuing uniqueness. Accepting differences in culture, gender, temperament, lifestyle, outlook, beliefs, values, commitments, taste and interests

The literature on using a Recovery approach to the nursing of people with dementia has been reviewed by Adams (2009) who similarly finds much that is useful and suggests a convergence of ideas in the promotion of wellbeing in people with dementia. Dementia may

signal the end of life, but it is not immediately fatal. If people are to make the most of the lives that are left to them then it is living with, rather than dying from dementia that is critical. As with people of all ages who develop other terminal physical illnesses, the challenge becomes one of living as valued and meaningful a life as possible:

- doing the things you value for as long as possible
- preserving a sense of personhood
- celebrating who you are and what you have achieved in life
- leaving a legacy for future generations (the gift of history)
- preparing 'advance statements' recording likes, dislikes, preferences so that others know when you are unable to tell them.

A diagnosis of dementia has a profound impact not only on the individual, but also on those who are close to them. Essentially, the challenge of 'Recovery' from a diagnosis of dementia involves families discovering new sources of value and meaning for themselves, in their loved one and in their relationship with them.

Recovery principles point to the need for a wider view of the service user than that of the purely bio-psychological orientation. Partnership working with Social Services is familiar to most Old Age Psychiatrists although substantial progress still needs to be made in this area. To provide comprehensive services and really promote inclusion multidisciplinary teams need to have access to knowledge about Welfare Benefits and sound relationships with Housing, Leisure Services and the Voluntary Sector.

Doctors have a leadership role in addressing issues of stigma, ignorance, prejudice and discrimination. Speaking to staff in other agencies, sharing our knowledge in service user forums, challenging ignorance and taking action where there is discrimination are all part of our role.

Older people's services in both the South West London and St George's (SWLSTG) and South London and Maudsley (SLAM) Trusts have taken on the challenge. At SWLSTG, following a series of qualitative interviews with older age service users, an action plan for the implementation of Recovery-orientated practice in older people's services was developed for both older people with functional mental health problems and those with dementias. The action plan was framed around the three headings of *Hope, Control and Opportunity*. As part of this, a series of publications are being produced. The first has been published for people with dementia and their families, 'Living well with dementia: An introduction to coping positively with dementia'. At SLAM a group of clinicians have obtained a research grant to investigate our understanding of what Recovery means for older people with mental health problems and to evaluate a training programme for frontline staff in the concepts of Recovery and Social Inclusion over a three year period. From 2010 onwards all frontline teams will receive team based Recovery training. There are also plans to offer training in 'coaching conversations' for staff to improve their communications skills.

Mental Health Older Age Clinicians at SWLSTG have produced materials that will be published on the Trust intranet. These include information on life review work, "advanced care directives" for people with dementia, and a booklet specifically for people with dementia

which uses the principles of the Recovery model to talk about coping with dementia at the point of diagnosis. The booklet has also been published. Currently planning is needed to ensure the dissemination of the materials and also a training strategy to ensure that the concepts are incorporated into everyday practice.

A Recovery-orientated approach in older people's services now needs to move from rhetoric to a reality in the way we provide our services. Embracing Recovery-orientated practice is important for older people with mental health problems if we are to enable the people who use our services to have sources of meaning and value, to be a part of their communities and contribute to those communities throughout their lives.

CHILDREN AND ADOLESCENTS

RECOVERY AND BUILDING RESILIENCE WITHIN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Recovery and social inclusion are important for everyone, including children and young people. *Every Child Matters* (Department for Education and Skills, 2003) identified five outcomes for every child and young person: to be healthy, to be safe, to enjoy and achieve, to make a positive contribution to society and to achieve economic well-being. These outcomes are universal ambitions for every child and young person, regardless of their background or circumstances, including those who have experienced mental health difficulties. Furthermore, these outcomes have much in common with the hopes and principles of Recovery.

The term 'Recovery' has raised some challenges for those who work in child and adolescent mental health as it could be taken to imply an approach to mental health care that lacks a developmental perspective. Recovery can be taken to mean a return to what has been before which, for young people and their families is not an option.

Whereas an adult may have confidence in who they are, a young person is still developing, discovering and exploring. A young person who has experienced mental health difficulties will be changing and recovering at the same time. It may be hard for them to feel that they are at a point of recovery as they are likely to come out developmentally different to how they were before.

A term which has been used by CAMHS professionals is *Resilience*, which can be broadly understood as a positive adaptation in circumstances where difficulties, whether personal, familial or environmental, are so significant that there would be an expectation that a person's cognitive or functional abilities would be impaired (Newman, 2002). Resilience is based on positive approaches with a focus on the strengths of the individual, growth and development. A key protective factor for children who have experienced severe adversity is the ability to recognise positive experiences, rather than focusing solely on the negative, and the ability to use these insights as a platform for affirmation and growth (Newman, 2002).

What is apparent with both the concepts and principles associated with Recovery and Resilience is the considerable overlap. The related concepts of hope, optimism, and future planning are key elements of both Resilience and Recovery approaches. The notion of the Recovery process as non-linear (acceptance of setbacks) is compatible with the characterisation of Resilience as changing over time. The explicit Recovery focus on peer support is also entirely compatible with a movement towards more central roles for families and the development of formal youth networks. In addition, Recovery can occur without professional intervention and resilient responses by children may often arise naturally, and may not always need to be stimulated by professional interventions.

Within South West London and St George's Mental Health Trust, a working group has been established to address what adopting Recovery-orientated practice means within CAMHS. The three key areas of the Recovery approach of hope, agency and opportunity have been translated by the group for CAMHS and linked to the five outcomes of *Every Child Matters*. This work will be carried forward by the Trust-wide CAMHS Forum.

ADDICTIONS

RECOVERY IN ADDICTION

Recovery has long been a core concept in the treatment of addiction. Often this has been narrowly defined with a focus on abstinence from illicit substances. The American Society of Addiction Medicine has described Recovery as a process of overcoming both physical and psychological dependence on a psychoactive drug with a commitment to abstinence based sobriety (Steindler, 1998). More recently the concept of Recovery has broadened after pressure from user led mutual aid groups and advocacy services. In 2007 the Betty Ford Institute Consensus Panel developed the definition of Recovery as “a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship”. Sobriety refers to abstinence from alcohol and other non prescribed drugs, personal health refers to improved quality of personal life and citizenship encompasses living with regard and respect for those around you as defined by validated instruments (Betty Ford Institute Consensus Panel, 2007).

The definition of Recovery needs to encompass several factors to make it a meaningful concept for treatment and health services. Firstly, as a lived experience by individuals and families, secondly as a concept connecting Recovery communities, thirdly as a measurable outcome that allows researchers and health services to quantify it, and finally as a goal or vision for health services (White 2007).

Many services see people with chronic addiction problems exacerbated by mental illness and social marginalisation. These individuals may have been accessing treatment such as methadone maintenance programmes or alcohol services with a long history of continued illicit use or relapse into alcohol. In addition there is increasing coercion for service users accessing addiction services led by the courts using alcohol treatment orders or drug restriction requirements instead of custodial sentences. As a consequence the concept of recovering (White 2007) is also important; a person may not have achieved abstinence but making steps towards that goal.

Many drug services focus on a model of harm reduction and medical stabilisation. In addition commissioners of substance misuse services often focus on narrow outcomes and fund services based on targets such as waiting list times and 12 week retention in treatment which neglects the Recovery strategy. Furthermore the Treatment Outcome Profile in Addiction (TOP) (Marsden et al, 2008) focuses on wider outcomes such as level of drug use, offending behaviour, general health, employment, education and housing, but again these are markers of improvement as defined by services, not the individual service user themselves. Though, in 2010, the National Treatment Agency has incorporated Recovery including reintegration into society for problem drug users in the standards for commissioners of addiction services (NTA, 2010).

In applying the three concepts of Recovery hope, agency and opportunity, psychiatrists can take a lead in promoting the model and incorporating current features of addiction treatment within a Recovery framework.

Hope

Hope is integral to mutual aid societies such as Alcoholics Anonymous and Narcotics Anonymous etc., as these organisations successfully promote self facilitation and engender hope. The use of narrative provides support from peers and 12 step facilitation therapy delivered by services can promote the use of fellowship organisations. More recently the National Treatment Agency has started to incorporate key principles of Recovery in its guidance articulating a vision of Recovery to staff, service users and commissioners. This vision of services includes instilling hope, repairing damaged lives and building social capital (Mitcheson, 2009).

Agency

People with drug and alcohol problems are often stigmatised by both health services and the wider society. This substantially reduces an individual's sense of control over and ability to manage their life. This is exacerbated by addiction where a person's life becomes controlled by a substance of dependence. There is evidence of treatment options than can improve an individual's agency within addiction.

Contingency management is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use. Consequently, it utilises social, recreational, familial, and vocational re-enforcers to assist service users in the Recovery process (Petry, 2000). The NTA is currently piloting this using financial rewards to promote appointment attendance, vaccination and clean urine testing. The initial evidence indicates this approach to be very successful in promoting positive behaviour and also encouraging service users to spend the money they earn in a way that promotes their Recovery e.g. equipment for a college course.

The ITEC (International Treatment Effectiveness Project) and BTEI (Birmingham Treatment Effectiveness Initiative) aim to improve treatment effectiveness to do this by making the delivery of psychosocial interventions both easier and clearer, and promoting organisational improvements. These approaches improve the quality of care planning through the use of a simple manual based on a cognitive approach known as 'node-link mapping'. This is a technique for discussing issues with service users and visualising them in a series of 'maps'. It can therefore help clients and key workers to clarify and focus on an issue and Recovery goals (NTA, 2009).

Opportunity

The concept of citizenship and participation in wider society is vital to Recovery in addiction and the use of peer support workers can facilitate opportunity. Recovering addicts are often core to rehabilitation programmes and voluntary sector organisations, providing treatment and support. Peer support has less of a tradition in statutory services but this is changing as both the voluntary sector and NHS start working in partnership.

Recovery is a core concept within addiction services both in the narrow sense of sobriety and abstinence, as well as within wider health improvements and societal involvement. The challenge is to incorporate Recovery in all its facets such as citizenship and hope in a milieu when services are measured on specific outcomes. As psychiatrists we can articulate this view in dialogue with service users, commissioners and staff.

FORENSIC

RECOVERY IN FORENSIC PSYCHIATRY

The three pillars of Recovery - *Hope, Agency and Opportunity* – apply to forensic psychiatry. Developing hope for the service user, opportunity for care providers/clinicians and ultimately control for the service user such that they can develop their individual capacities. Recovery does not, in this regard, disempower the doctor but instead inspires them through the application and development of these three pillars. Perhaps hope is not just for the service user but also for the clinician.

Undoubtedly the application of the concepts of recovery within forensic services has challenges as a result of the involvement of Ministry of Justice, MAPPA and other statutory services such as Probation. Comments from service users such as “I don’t have to do what my doctor tells me”, or “I don’t have to live where I am told” are understandable but are not going to be possible within forensic services. Nevertheless even though the implementation of recovery-orientated practice may be more complicated, it may be a valuable way of operationalising forensic practice and how to affect change in the service user.

Working in a recovery approach regains compassion as a central part of the interface between clinician and service user. The similarities between humanism and recovery are recognised (Roberts and Wolfson, 2004). Recovery-orientated practice is just as applicable within forensic services as it is in other mental health services. Forensic services need to be particularly interested to consider whether and how detention and compulsion could be routes to personal recovery (Roberts et al, 2008).

“The therapeutic purpose of detaining someone and treating them against their will is to achieve the gradual handing back of choice and control in ways that are safe and to enable them to resume responsibility for themselves.”

(Roberts et al, 2008, pages 173-174)

Recovery-orientated practice within forensic psychiatry promotes the normalisation of service users and also promotes their social inclusion. Examples of such practice involves theatre, museum and football trips that allows greater equalisation between staff and service users and will ultimately promote reality testing and community reintegration leading to increased safety and respect for security.

Importantly, recovery-orientated practice is not a treatment but a collaborative approach which promotes hope and hope inspiring relationships. If we are to really promote hope then we need to help service user to accommodate what has happened, help them see they are more than a ‘forensic patient’ and help them to see that a decent life is possible. The role of peer support in forensics is vital.

It is important to remember that personal recovery is not about the absence of illness. For example, some service users might see steps towards their Recovery as the achievement of moving out of high dependency care or sharing responsibility about managing acute relapse of illness. For others engaging in those activities that give their lives meaning within the service (spirituality, education or work) and for others retaining links with their communities maybe seen as part of a person’s recovery.

One of the criticisms of recovery-orientated practice is its capacity to be at times woolly or opaque. Within forensic psychiatry recovery is considered an essential part of modern practice in that it allows the empowerment of service users and aims to maximise people's strengths and abilities. The evidence base for recovery in forensics is developing, but we should not just be concerned about evidence based practice but also practice-based evidence, which means learning from what you are doing. In this regard service users contribute to practice-based evidence as experts.

Within forensic services the management of risk is paramount. If a person harms themselves or other people, or is vulnerable to abuse from others, then this severely restricts their possibilities for rebuilding a meaningful and valued life. However, pursuing opportunities necessarily involves taking the risk of being unsuccessful. Our task is to support people in taking such risks and help them to build on failures that do occur rather than protecting them from the possibility of failure. We need to embrace recovery-orientated practice and worry less about the perceived risk of inclusion. Through such an approach a service user is more likely to turn to their clinician with whom they have an effective working relationship at the point of challenge rather than withdrawal. Encouraging and supporting service users to develop personal recovery plans (or WRAP) along with developing and negotiating advance directives within the parameters that society sets is one way to enable service users to maximise choice and control over the treatments, interventions and support they receive.

There is often concern about giving service users greater choice and control but service users tell us that it is often the small things that make the biggest difference: People having their own appointments diaries; having a choice of time to get up, therapy, activities, how to use 1:1 sessions. Within both Trust's service users have been developing portfolios which include certificates of treatments completed, risk assessments, such as the HCR-20, assessment reports and vocational skills certificates. Portfolios are held by the service user and taken to Tribunals and CPA reviews. They demonstrate to the service user and others how their health is improving.

In addition, at SLAM, a five-item quick questionnaire has been collaboratively developed with service users and Amy Batson and Timothy Green measuring ideas of hope and control for the service user. In particular, this questionnaire develops the concept of inter-dependency which perhaps is a central factor for affective recovery for the mentally disordered offender. Inter-dependency is about shared responsibility and collaboration within a care programme towards safe and effective release to the community. Inter-dependency recognises the input of other bodies, such as the Ministry of Justice, but ultimately concludes how the service user, not just a clinical team, is responsible for ensuring the safety of others. At South West London service users who have moved on from services have been encouraged to write personal accounts of their recovery journeys. A collection of these personal accounts has been published and is widely available to all service users, their family, friends and carers and staff within the forensic service. Ex-service users are invited to come back, run groups and provide role models for existing service users to see there is life after forensic services

We have moved forward but need to move further to encourage service users to be involved in the development of their care plans and in the assessment and management of their risk assessments. Working collaboratively, based on shared decision making, promotes a more positive working alliance that promotes hope, shares risk and the management of crisis.

Recovery as an approach to service delivery is helpful for forensic services as it ultimately operationalises relational security.

In conclusion there is minimal difference between recovery processes within forensic psychiatry compared to generic services. Recovery emphasises the importance of parameters within forensic clinical practise and encourages a healthy shift away from punitive concepts that have become increasingly dominant in forensic services. Although public enquiries into homicides have given rise to concerns around service users being given too much independence, ultimately such worries are misplaced. Recovery promotes the concept that control and responsibility has to be shared between clinician and service user. This undoubtedly assists in the 'management of trust'.

LEARNING DISABILITY

RECOVERY IN LEARNING DISABILITY SERVICES

In parallel with the developments in generic mental health services, the services for people with learning disabilities over the last 30 years has moved from institutional to community care. This shift has been underpinned by overt and strong philosophies which have profound similarities to the principles and values of Recovery, including Normalisation (Wolfensberger, 1972), Social Role Valorisation (Wolfensberger, 1983), Ordinary Living (King's Fund, 1980), Service Accomplishments (O'Brien, 1989), Needs Assessments and Essential Lifestyle Planning / Person Centred Planning (PCP) principles and approaches.

Government policy over the past decade for people with learning disabilities (Department of Health, 2001; 2005) has several aspects of the Recovery approach and has put independence, choice and inclusion at the heart of its developments. The 'Valuing People' Strategy (VPS) set out aspirational values for the future lives and service delivery for all people with learning disabilities: rights as citizens, inclusion in local communities, choices in daily life and real chances for independence. In this approach, the appropriateness of mainstream primary care, secondary care, mental health, social care and other services for people with learning disabilities should be determined through multi-professional/inter-agency individual needs-led Person Centred Planning (PCP) principles and approaches. The All Wales Strategy for the Development of Services for Mentally Handicapped People (launched in 1983) was pioneering in its commitment to enable people with learning disabilities to have "normal patterns of life within the community, to be treated as individuals and to receive additional help and support from the communities in which they live and from professional services in developing their maximum potential".

Despite the aspirations of policy, many people with learning disabilities and mental health needs will still require access to specialist, community-based, out-patient, inpatient and secure mental health learning disabilities services. These people include those with moderate to profound learning disabilities and limited verbal communication skills and those with continuing complex mental health (and other) needs including those with severe enduring mental illness, personality disorders, challenging or offending behaviours, autism, dementia, complex genetic and neuropsychiatric disorders including epilepsy. Given the important role that mental health services play in the lives of many people with learning disabilities, it is essential that they, along with their partners in social and independent sector services, take up and adapt the principles of Recovery in the development of their services and practice.

In some localities, people with learning difficulties and mental health needs access mainstream and specialist mental health services with varying degrees of social and service inclusion planning, facilitation or joint working with learning difficulty services. Examples of these include service users with borderline or mild learning difficulties and co-morbidities such as major mental health problems, Asperger's syndrome, ADHD, alcohol and substance misuse, early onset dementias, and head injuries with or without challenging and offending behaviours.

The problem of access to basic services, especially main stream services, is particularly pertinent for people with learning disabilities. O'Brien (1989) highlighted the difficulties

experienced in achieving and sustaining social inclusion, suggesting that prejudice towards people with severe disabilities is perpetuated by their exclusion from “ordinary classrooms, workplaces and homes”. In what have come to be known as *O’Brien’s five accomplishments*, he defines the quality of supported lives of people with learning disabilities in relation to valued inclusive experiences of growing in relationships, contributing, making choices, having the dignity of valued social roles, and sharing ordinary places and environments. These accomplishments are phrased in terms of exclusion, rather than inclusion, and each accomplishment is seen as “challeng(ing) and strengthen(ing) the relationship between people with disabilities and other community members” (O’Brien, 1989).

If Recovery is about having a satisfying and fulfilling life *as defined by each person* then it has the same relevance to those using and working in Learning Disability services as it does for mainstream mental health services. Learning disability includes the presence of significantly reduced ability to understand new or complex information or to learn new skills with a reduced ability to cope independently. It is a life-long condition in which the person needs extra help to maximise their abilities and access opportunities. Nonetheless, people with learning disabilities can lead full and rewarding lives (as many already do) but others find themselves socially excluded due to stigmatisation and the subsequent discrimination.

For people with learning disabilities a full clinical recovery may not always be achievable. The principles of Recovery recognise service users as experts in their own conditions and the emphasis is not just on the clinical recovery but on what happens in the wider part of their lives. The potential benefits for the individual are to improve their social outcomes in terms of employment, to strengthen their social network and relationship with the wider society. The economic benefits may be in keeping service users less in need of mental health services and increasing their opportunities for paid employment. Recovery means not necessarily a change in service but a change in our practice of working in partnership with service users to improve both their clinical and social outcomes. In order to support the Recovery of service users, mental health practitioners must work much more in partnership with the wider community services and networks.

The three core concepts of Recovery provide an ideal summary of principles for people with learning disabilities.

Hope

Hope and motivation to achieve more fulfilling lives is crucial to the well-being of service users with learning disabilities including those making the Recovery from severe mental ill-health and it is essential for their families and carers. The personal qualities of staff are important in encouraging a positive approach and working together as partners in the service user’s Recovery.

Agency

Advocacy and self empowerment have grown in the lives of people with learning disabilities and have become more evident over recent years so giving people with learning disabilities more control over their daily lives with increased independence and choice. The involvement of service users and carers in the delivery and planning of services has increased, for example, through local partnership boards (Department of Health, 2001; 2009). The personalisation agenda is increasingly being incorporated into services for people with

learning disabilities for example through a *person centred approach* looking to improve outcomes in terms of social inclusion, empowerment and equality.

People with learning disabilities require greater control of their lives, improved access to health care and to have more fulfilled lives in their local community including friendships and relationships. Presently, less than 10% of people with learning disabilities have jobs.

Opportunity

A strong values base related to social inclusion has underpinned service development for people with learning disabilities over the past 30 years. People with learning disabilities have rights as citizens; they want to participate in their local communities, to have choices in daily life and to experience real chances for independence. They require access to appropriate mainstream primary and secondary physical and mental health care. Health and Social care and other services should be determined through principles and approaches which are needs-led and patient-centred in a multi-professional and inter-agency manner.

The opportunity to have more socially inclusive lives will require support to service users but also a recognition that we need to challenge the beliefs of wider society. Recovery for people with learning disabilities will need to emphasise the importance of relationships, access to a diverse range of social and leisure activities and opportunities for fulfilling occupational lives.

The ideas of Recovery are key to improving the life chances of people with learning disabilities by promoting social inclusion with the ideas of agency and opportunity being essential to achieving better outcomes for people with learning disabilities and severe mental ill-health.

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