Chapter 3

Recovery and Mental Health

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Introduction

The term 'recovery' has become widely used in mental health systems internationally. Empirical (Resnick et al., 2005) and conceptual (Whitley and Drake, 2010) approaches have been used to differentiate aspects of recovery. However, it can be most useful to consider two contrasting understandings: clinical recovery, meaning recovery from mental health difficulties, and personal recovery, meaning recovery with mental health difficulties (Slade, 2009b). Both meanings are underpinned by sets of values and create role expectations for mental health professionals and for people using mental health services. The distinction between the two meanings reflects a debate about the core purpose of mental health systems.

Meaning 1: Clinical Recovery

Clinical recovery has emerged from professional-led research and practice, and has four key features:

1. It is an outcome or a state, generally dichotomous – a person is either 'in recovery' or 'not in recovery'.
2. It is observable – in clinical language, it is objective, not subjective.
3. It is rated by the expert clinician, not the patient.
4. The definition of recovery does not vary between individuals.

Various definitions of recovery have been proposed by mental health professionals. A widely used definition is that recovery comprises full symptom remission, full- or part-time work or education, independent living without supervision by informal caregivers, and having friends with whom activities can be shared, all sustained for a period of two years (Libermann and Kopelowicz, 2002).

The definition of clinical recovery does not vary across individuals, which means it is relatively easy to define, measure and investigate in empirical studies. A review of all epidemiological prevalence studies in schizophrenia assessing recovery over more than a 20-year follow-up period indicated that rates of clinical recovery in excess of 50% are the norm (Slade et al., 2008).

However, deep assumptions about normality are embedded in clinical recovery:

> This kind of definition begs several questions that need to be addressed to come up with an understanding of recovery as outcome: How many goals must be achieved to be considered recovered? For that matter, how much life success is considered "normal"?
>
> (Ralph and Corrigan, 2005) (p. 5)

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A different understanding of recovery has emerged from the mental health service user and survivor movement. This can be called personal recovery.

Meaning 2: Personal Recovery

In contrast to clinical recovery, personal recovery

1. is a process or a continuum
2. is subjectively defined by the person him- or herself
3. is 'rated' by the person experiencing the mental health difficulties, who is considered the expert on his or her recovery
4. means different things to different people, although there are aspects that many people share

Personal recovery has a different focus than clinical recovery, for example in emphasising the centrality of hope, identity, meaning and personal responsibility (Andresen et al., 2003). The most widely cited definition, which underpins most recovery policy internationally, is by Bill Anthony:

> Recovery 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 within 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)

Since recovery has a personal meaning for each individual, it can be difficult to find a shared definition. In a Delphi study with 381 participants, all of whom had personal experience of psychosis, the largest number of participants agreed on the statements 'recovery is the achievement of a personally acceptable quality of life' and 'recovery is feeling better about yourself' (Law and Morrison, 2014).

This distinction between the different understandings of recovery has been characterised in different ways: recovery 'from' versus recovery 'in' (Davidson et al., 2008); scientific versus consumer models of recovery (Bellack, 2006); clinical recovery versus personal recovery (Slade, 2009a) or versus social recovery (Secker et al., 2002).

It is this second understanding of recovery – perhaps most commonly called personal recovery – which is meant when policies or services refer to supporting recovery, using a 'recovery approach' or being based on a 'recovery model'. This is the meaning of recovery used in the remainder of this chapter.

Recovery and Policy

A recovery orientation is embedded in national mental health policy in many countries across the Anglophone world (Department of Health and Ageing, 2009, Mental Health Commission of Canada, 2012, Department of Health Social Services and Public Safety (Northern Ireland), 2010, New Freedom Commission on Mental Health, 2003, HM Government, 2011) and elsewhere (Slade et al., 2012a, Olij, 2009).

At least rhetorically, recovery has also been embraced by professional groups. In England, for example, the principles of recovery have been adopted in clinical psychology (Cooke, 2014), mental health nursing (Department of Health, 2006), occupational therapy (College of Occupational Therapists, 2006), psychiatry (Care Services Improvement Partnership, 2007) and social work (Allen, 2014). Perhaps the most influential professional group

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internationally is psychiatry in the United States, which has also embraced the term (American Psychiatric Association, 2005).

A Conceptual Framework for Personal Recovery

To provide a framework to inform understanding of how personal recovery can be defined and measured and the process by which it can take place, a systematic review was undertaken to collate and synthesise published frameworks and models of recovery (Leamy et al., 2011). A total of 97 papers from 13 different countries which offered new conceptualisations of recovery were identified, based on 366 reviewed papers. Narrative synthesis (Popay et al., 2006) was used to develop a conceptual framework. The synthesis was subsequently shown to be applicable across Western cultures (Slade et al., 2012b) and consistent with the understanding of recovery held by current mental health service users (Bird, 2014c).

The narrative synthesis identified

1. Thirteen characteristics of the recovery journey, for example, recovery is an active process, individual and unique process, nonlinear process, recovery is a struggle, recovery is a life-changing experience, recovery is possible without cure. These help in understanding the subjective experience of recovery.
2. Thirteen published stage models of recovery, all of which can be mapped to the Transtheoretical Model of Change (Prochaska and DiClemente, 1982). These describe how distinct stages of recovery can be differentiated.
3. Five overarching recovery processes comprising connectedness, hope and optimism about the future, identity, meaning in life and empowerment (giving the acronym CHIME). The CHIME framework has proved useful as a focus for understanding recovery (Wyder, 2014) and in identifying how mental health workers can support recovery (Eriksen, 2014).

The CHIME framework can inform the development of new interventions. There is empirical evidence for interventions addressing each of these five domains.

Connectedness

Despite the many policies (South Australian Social Inclusion Board, 2007) and books (Boardman et al., 2010) highlighting the importance of social inclusion, empirical research into interventions which improve connectedness is limited (Tew, 2012). The strongest evidence base relates to employment and meaningful activities (Crowther et al., 2001), with the Individual Placement and Support model (Killackey et al., 2008) showing particular promise. There is some evidence for interventions to support relationships with others, including for example the beneficial impact of meeting other people with personal experience of mental health problems – either through their employment as peer support workers within the mental health system (Repper and Carter, 2011) or (with weaker evidence) through mutual self-help groups (Slade, 2009b). A number of national anti-stigma campaigns have been undertaken internationally, using three broad approaches: educational lectures and information, video-based media and social contact with individuals with lived experience. A review of such interventions indicated that direct social contact with people with mental health problems was the most effective method of changing attitudes towards mental health problems (Clement, 2011), and the first empirical evidence of a shift in societal attitudes following a national campaign is emerging (Henderson et al., 2012).

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Hope and Optimism

A systematic review of candidate interventions for fostering hope identified promising interventions including collaborative illness management strategies, fostering positive relationships, peer support and support for setting and attaining realistic personally valued goals (Schrank et al., 2012). A specific approach is Wellness Recovery Action Planning (WRAP), which is an evidence-based strategy used internationally to promote wellness and recovery through the development of coping strategies (Copeland, 1999). WRAP stands out as an intervention which has been widely evaluated using both randomised and nonrandomised designs. Positive outcomes include increased hopefulness (Barbic et al., 2009; Cook, 2011; Fukui et al., 2011), among others. Receiving peer support from peer support workers or mentors who have themselves experienced mental health difficulties has also been shown to increase hopefulness when compared with treatment as usual, with additional recovery benefits noted for the peer workers themselves (Davidson, 2012).

Identity

Interventions to support the development and maintenance of a positive identity are lacking. Approaches which are worth developing as intervention technologies include life-story work, Tree of Life and narrative therapy. For example, life-story work aims to help individuals develop their personal narratives and has been shown to be effective in people with dementia (Subramaniam and Woods, 2012). A key challenge for future research will be developing interventions which are sensitive to nonindividualistic expressions of identity – an emphasis on collective identity is one way in which the experience of recovery differs for individuals from BME communities (Leamy et al., 2011). Finally, symptom severity is linked to the integrity of the person's narrative (Lysaker et al., 2012), so evidence-based interventions which directly address symptoms may also contribute to the development of a more positive identity.

Meaning and Purpose

Meaning and purpose in life find expression in many ways, but one key aspect is through spirituality and religion. Unfortunately, these domains are not only deprioritised but often actively excluded from clinical discourse. For example, an intervention involving spiritual assessment by psychiatrists showed benefits for service users but low acceptance by participating psychiatrists (Huguelet et al., 2011). Other professional groups are more amenable to spirituality discussions (Post and Wade, 2009), and the approach is starting to be incorporated into psychological therapies (Hathaway and Tan, 2009).

More generally, a sense of purpose can be gained from amplifying strengths (Gander, 2012), for example by setting and working towards personally valued goals. Staff can have an important role in supporting this process, and giving staff goal-setting training improves the quality of the goal plans they are able to support. Additionally, supporting people in becoming aware of their values, and linking these with their goals, can ensure that goals are intrinsically meaningful to the individual (Clarke et al., 2009).

Empowerment

Several interventions have been developed which target personal responsibility and control, including advance directives (Swanson et al., 2006), joint crisis plans (Henderson et al.,

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2004) and shared decision making (Drake and Deegan, 2009). A specific well-evaluated and widely used approach is the strengths model of case management, which focuses on the relationships between staff and consumers, prioritises strengths over deficits, is consumer-led and actively promotes resource acquisition through advocacy (Rapp and Goscha, 2006). Evaluations have included randomised controlled trials and quasi-experimental designs, and have shown a range of positive outcomes including reduced hospitalisation, increased social support, goal setting and goal attainment.

As well as supporting people in taking a more active role in their own recovery, empowerment can also be supported by involvement in the development, delivery and evaluation of mental health services. Mental health services internationally are increasingly involving people with personal experience of mental health problems in the recruitment and training of staff, in service development, in the workforce (Tait and Lester, 2005), in mental health service research and evaluation and in policy making (Callard and Rose, 2012). Examples of some of these initiatives are given in Chapters 14, 15 and 16. Despite many challenges associated with achieving meaningful involvement and partnership, the subjective ability to exercise greater choice and control has been reported by involved service users (Omeni et al., 2014),

Positive psychology interventions, such as positive psychotherapy (Seligman et al., 2006), also identify and amplify an individual's capabilities and resources through the therapeutic process, with the aim of developing positive mental health including resilience and uplifting emotional experiences. These interventions can be provided on line, and benefits have been shown for depressive symptomatology (Lopez and Edwards, 2008), reduced service use (Duckworth et al., 2005) and self-rated happiness (Seligman et al., 2005). The modification and evaluation of positive psychology interventions for psychosis are described in Chapters 6 and 12 respectively.

How Mental Health Services Can Support Recovery

Although guidance on recovery-oriented practice exists, there remains a lack of clarity regarding best practice (Lakeman, 2010). An empirically based framework to guide recovery practice was therefore developed to address this knowledge gap (Le Boutillier et al., 2011). The practice framework was developed by analysing 30 documents from six countries (Denmark, England, New Zealand, Republic of Ireland, Scotland, United States of America) detailing international practice guidance on supporting recovery. Inductive thematic analysis was used to systematically identify and synthesise the range and diversity of the key concepts of recovery-oriented practice identified in the reviewed documents. Interpretive analysis was then undertaken to organise the themes into practice domains.

Four overarching levels of practice emerged from the synthesis: supporting personally defined recovery; working relationship; organisational commitment and promoting citizenship. Each practice domain is as important as the next, and there is no hierarchical order. The first two domains involve the content and process of care, and are being actively addressed in person-centred approaches (Tondora, 2014) and through emergent technologies such as the Collaborative Recovery Model (Crowe et al., 2006) described in Chapter 9. The third domain is being addressed through national transformation programmes, such as ImROC in England (NHS Confederation Mental Health Network, 2012), Partners in Recovery in Australia (Australian Government, 2012) and Recovery to Practice in the United States (http://www.samhsa.gov/recoverytopractice/). This has led to the development of new ways

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of providing support, such as Recovery Colleges (Perkins, 2012). Progress on the fourth domain of promoting citizenship, as noted in Chapter 1, is much more limited.

A recent review identified ten evidence-based approaches to supporting recovery (Slade, 2014). The evidence base for recovery-supporting interventions is increasingly robust. As an example, the REFOCUS intervention is a manualised transdiagnostic team-level intervention to improve mental health service support for recovery (Bird et al., 2011). It comprises a one-year whole-team intervention aiming to impact team and individual staff values (which can be conflicting) (Le Boutillier, 2015), recovery-related knowledge, skills and behaviour and staff–patient relationships. The intervention has two components: behavioural and interpersonal. The behavioural component comprises three desired behaviours by staff, called working practices (WPs). WP1 is Understanding Values and Treatment Preferences and involves focussing on the patient's values and identity beyond being a patient and placing these preferences at the centre of care planning. WP2 is Assessing Strengths and involves using a standardised assessment of personal and social strengths to identify existing and potential resources the patient can build on. WP3 is Supporting Goal-striving and involves orienting clinical care around goals valued by the patient. These working practices are undertaken in the context of the interpersonal component, called recovery-promoting relationships, which included training staff to use coaching skills in interactions with patients (Grey, 2014) and undertaking a partnership project, in which staff and patients from the same team take on a joint and nonclinical task, co-produced between staff and patients.

The development of the REFOCUS intervention was informed by primary research and secondary systematic reviews addressing knowledge gaps (Slade, 2015b). The REFOCUS intervention targets the supporting recovery and working relationships practice domains of the practice framework outlined earlier (Le Boutillier et al., 2011). The CHIME framework, also described earlier, provides the focus for intervention and evaluation (Leamy et al., 2011). A systematic review of strengths measures identified the best measure to use in WP2 (Strengths Assessment) (Bird, 2012). The optimal primary outcome for the trial of REFOCUS was based on a systematic review of recovery measures (Shanks et al., 2013). A separate systematic review of recovery support measures concluded that no existing measure was suitable (Williams et al., 2012), so a new measure of recovery support based on the CHIME framework and called INSPIRE was developed and psychometrically evaluated(Williams, 2015). A grounded theory of staff experiences of supporting recovery was developed (Le Boutillier, 2015) to understand staff perspectives. A new measure of feasibility based on implementation science research was developed to maximise implementation (Bird, 2014a). Innovative approaches to individualising trial endpoint measurement were evaluated (Pesola, 2015). In line with best scientific practice (Craig et al., 2008), a testable model (Bird et al., 2011) and trial protocol (Slade et al., 2011) were published in advance of the evaluation.

The results of the randomised controlled trial (ISRCTN02507940) involving 403 service users from 27 community-based adult mental health teams indicated that the intervention was effective at improving recovery when adequately implemented (Slade, 2015a), and implementation challenges were explored in process evaluation (Leamy, 2014). An unpublished thematic analysis of interviews conducted with people who had received the REFOCUS intervention indicated that a working relationship that is collaborative, in which the staff member demonstrates 'genuine' interest in the individual, was felt to support recovery. Participants highlighted that recovery-supporting tools exploring strengths, goals and

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values and treatment preferences could support personal recovery by helping the person feel more hopeful and empowered, with a more positive sense of identity. However, they also highlighted that the tools must be used collaboratively and the resulting information used to inform care planning, with a need to avoid attempts to 'do' recovery 'to' service users by focusing on the development of hope-inspiring, power-balanced relationships. These findings are in line with a previous qualitative study in which service users were asked how professionals could support them in their recovery process (Borg and Kristiansen, 2004). The value of professionals who conveyed hope, shared power, were available when needed, were open regarding the diversity in what helps and were willing to stretch the boundaries of what is considered the 'professional' role was highlighted. The REFOCUS intervention manual was updated based on these findings (Bird, 2014b).

Other approaches with a strong evidence base include peer support workers (Pitt et al., 2013), advance directives (Swanson et al., 2006), wellness recovery action planning (Jonikas et al., 2013), and individual placement and support (Grove, 2009). Additionally, recovery colleges (described in Chapter 16) (Perkins, 2012) and trialogues (Amering, 2012) are also widely used to support recovery.

The development of an empirical evidence base for supporting recovery indicates strong overlap with wellbeing research. Points of linkage include the emphasis on connection, the importance of developing a layered and resilient identity, the focus on strengths amplification rather than deficit amelioration and the need to contribute as well as receive. Recovery research is being influenced by wellbeing, for example, in the emphasis in the REFOCUS intervention on coaching to support goal striving. Similarly, emergent findings about the importance of lived experience as a source of knowledge in the context of recovery can inform approaches to increasing wider societal wellbeing. In the longer term, it may be that recovery – which is inextricably linked to illness – becomes redundant as services orient around the goal of supporting wellbeing in people living with mental health problems.

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