

the experience of psychiatric symptoms (Harrison *et al.*, 2001). It may be that sociological context will be just as crucial to the adoption and advancement of recovery and subsequent systems transformation in those nations.

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## RECOVERY

# Implementing recovery in mental health services

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**The ideas of 'recovery' arise from the experiences of people with mental health problems. The recovery approach emerged in the North American civil rights and consumer and survivor movements from the 1970s onwards. It is concerned with social justice, individual rights, citizenship, equality, freedom from prejudice and discrimination. In this paper we discuss a project in England that has examined how mental health services may be transformed to be more supportive of recovery and the implications that this has for professional practice.**

The ideas that are subsumed under the heading of 'recovery' are not new: they have their roots in the history of psychiatry (Davidson *et al.*, 2010). Their recent history specifically reflects the intellectual output and lived experience of people with mental health problems, particularly psychoses. The contemporary roots of recovery ideas also lie in the civil rights and consumer and survivor movements that emerged in North America from the 1970s onwards. In this, people were declaring that their symptoms and incapacities need not permanently impede their achievement of personally valued life goals, and not only did mental health services

need to change to recognise the legitimacy of these objectives, but also a social transformation was necessary to deal with the stigma and exclusion that are still commonly experienced by people with mental health problems in most societies (Frese *et al.*, 2009).

### What is recovery?

Recovery can be seen as a set of ideas and principles derived from the experiences of people with mental health problems and is associated with a movement calling for social justice, individual rights, citizenship, equality, freedom from prejudice and discrimination. When we talk about 'recovery' nowadays we are not necessarily talking about 'clinical recovery' (symptom reduction) but rather the process of helping people to live a life 'beyond illness' – that is, the recovery of a meaningful life, with or without symptoms. This is usually known as 'personal' or 'social' recovery (Slade, 2009).

Analysis of the accounts of people who have direct experience of mental health problems suggests that three concepts are central to recovery (Repper & Perkins, 2003; Shepherd *et al.*, 2008). These are: *hope* (sustaining motivation and supporting expectations of an individually fulfilled life), *agency* (recovering a sense of personal control) and *opportunity* (using circumstances to gain

personally valued goals). Recovery is, then, seen as a journey, a process through which people attempt to increase their sense of hope, agency and opportunity. Hence, people speak about being 'in recovery', rather than 'recovered'. The challenge for services and practitioners is then to think about their contributions to these processes. Are they supporting them, or getting in the way?

### Recovery and mental health policy – national and international perspectives

In recent years, the principles of recovery have influenced mental health policy in several English-speaking countries, including the UK, Ireland, the USA, Canada, Australia and New Zealand, and there are many good examples of recovery-oriented services and practices. However, we know that the implementation of complex policies in mental health is challenging and the results are often rather patchy: so it is with recovery.

In England, the objectives of recovery are now well established in mental health policy. Thus, a 2011 strategy document from the Department of Health (*No Health Without Mental Health*) contains six key objectives, one of which is that 'More people with mental health problems will recover' (p. 7). It goes on to state what this means:

More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.

In addition, all the major professional organisations in England and Wales (nursing, psychology, occupational therapy, social work) have voiced their support for recovery ideas, including, notably, the Royal College of Psychiatrists (Royal College of Psychiatrists *et al.*, 2007).

In England, we have closed our large mental hospitals and have developed a much clearer structure for community services. But we still need to improve the content and quality of these services

and the experience of those who use and work in them. For these challenges, the ideas of recovery can provide the guiding principles.

### Taking a recovery perspective – the organisational challenges

The ideas of recovery arise from the experiences of people who have used mental health services. These ideas do not constitute a 'theory' of mental illness, nor are they a new form of 'treatment'. Clinicians and the mental health services cannot make people 'recover'. They can only try to support their recovery in a positive way. So, what does this mean for the practice of clinicians, as well as for the structure and the culture of mental health services? How can they become more 'recovery oriented'?

At the Centre for Mental Health in London (an independent, not-for-profit, research and consultancy centre) we have been developing a framework to address this question. Through consultation with stakeholders (clinicians, managers, service users, carers, commissioners etc.) and a thorough review of the literature, we have produced a list of key challenges that mental health services have to face in order to make their services more recovery oriented (see Box 1). Behind these challenges is the proposition that the ideas of recovery must go right through the organisation, influencing it at every level. Thus, there needs to be a fundamental change in the quality of day-to-day interactions. Every interaction, by every member of staff, should confirm recovery principles and promote recovery values. Training of both staff and service users is central to this. Fundamentally, the training should be co-produced between professional staff and service users and this will require a cadre of trained and supported service users to act as peer trainers. We suggest the creation of a 'recovery education centre', jointly run by staff and service users, in each mental health provider organisation within the National Health Service (NHS) to support these developments.

However, training will not be sufficient on its own. We know from studies of attempts to embed recovery principles into services that, in addition to training, we need to take into account the management and supervision of staff, the quality of leadership and the organisational culture within which this training is delivered (Whitley *et al.*, 2009). Recovery values need to be embedded into every management process: recruitment, supervision, management and appraisal, and the development and implementation of operational policies. This means support and leadership from the top of the organisation as well as developments from the 'bottom up'.

Important policies may also need to change. For example, risk assessment and management need to become more open, transparent and co-produced. The 'involvement' of service users should be redefined to reflect a much greater emphasis on 'partnership' working, and consideration should be given to the employment of a

#### Box 1 Ten key organisational challenges

- 1 Changing the nature of day-to-day interactions and the quality of experience
- 2 Delivering comprehensive, user-led education and training programmes
- 3 Establishing a 'recovery education centre' to drive the programmes forward
- 4 Ensuring organisational commitment, creating the 'culture'. Leadership
- 5 Increasing 'personalisation' and choice
- 6 Transforming the workforce (training and deployment of peer professionals)
- 7 Changing the way we approach risk assessment and management
- 8 Redefining user involvement to achieve true partnership working
- 9 Supporting staff in their recovery journey
- 10 Increasing opportunities for building a life 'beyond illness' (e.g. 'individual placement and support')

Source: Sainsbury Centre for Mental Health (2009).

much greater proportion of appropriately trained and supported 'peer support workers' (Repper & Carter, 2011).

Staff also need to be supported in *their* recovery journeys; their 'lived experience' should be valued, as should the contribution that this can make to their professional roles.

Finally, the organisation needs to increase its partnerships with non-mental health agencies (housing, education, employment, leisure) to support the social inclusion of service users.

### **The Implementing Recovery – Organisational Change (ImROC) project**

We are now engaged in a major national project, Implementing Recovery – Organisational Change (ImROC), aimed at helping organisations become more supportive of recovery. It has been devised to support the Department of Health's 'No Health Without Mental Health' strategy, with its emphasis on supporting recovery for individuals, and is jointly funded by the Department of Health and by contributions from participating sites.

The project is aimed at helping mental health organisations to develop in a more recovery-oriented way using the ten key challenges listed in Box 1. An organisation is asked to identify which challenges it wishes initially to work on and it is then set specific targets for changing in this direction (Shepherd *et al*, 2010). Once the goals are agreed, the process of change is implemented and progress is monitored. The goals may then need to be adjusted. New goals are set and the cycle repeated. This form of internal audit loop (the 'plan-do-study-act' cycle) has been recommended as the most effective process for producing sustained organisational change (Iles & Sutherland, 2001).

The project began on 1 April 2011 and over 30 English NHS mental health trusts applied. Twenty-nine were eventually accepted and they were assigned to one of three categories: 'demonstration' sites ( $n=6$ ), which are already well advanced; 'pilot' sites ( $n=6$ ), which were those that seemed most likely to benefit from intensive help; and 'network' sites ( $n=17$ ), which have joined a learning network with the other sites and attend regular, themed 'learning sets'.

All the pilot sites have now identified their key challenges and are working through them. The major developments are around the joint training of staff and service users (training is jointly delivered and jointly received), support for team leaders and key clinicians, review of key policies and work with the trust boards (most senior managers). Many sites are also preparing to train and support a new cohort of peer support workers.

### **International relevance**

As indicated above, interest in developing mental health services to support recovery is already common in the English-speaking world and

many European nations are also moving in this direction. However, there has been less interest in middle- and low-income countries. This is a little surprising given the importance of informal supportive networks in many such countries and the relatively low cost of the 'technology' associated with developing a recovery orientation (e.g. joint training, partnership working with local user groups, peer support workers and the establishment of local recovery education centres).

There are, however, some signs of progress. For example, the East London NHS Foundation Trust has an established link with Butabika hospital in Kampala, Uganda, which promotes training and development (Baillie *et al*, 2009). This link has facilitated the development of Heartsounds, a local service user organisation whose membership includes 55 service users, 10 professionals, more than 25 well-wishers from the community and over 300 online members. In collaboration with Heartsounds we are planning to provide core training in the recovery approach to a Kampala community recovery team and service user leaders, and then to begin a training programme for peer support workers. These are exciting developments and it will be fascinating to see how they progress.

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