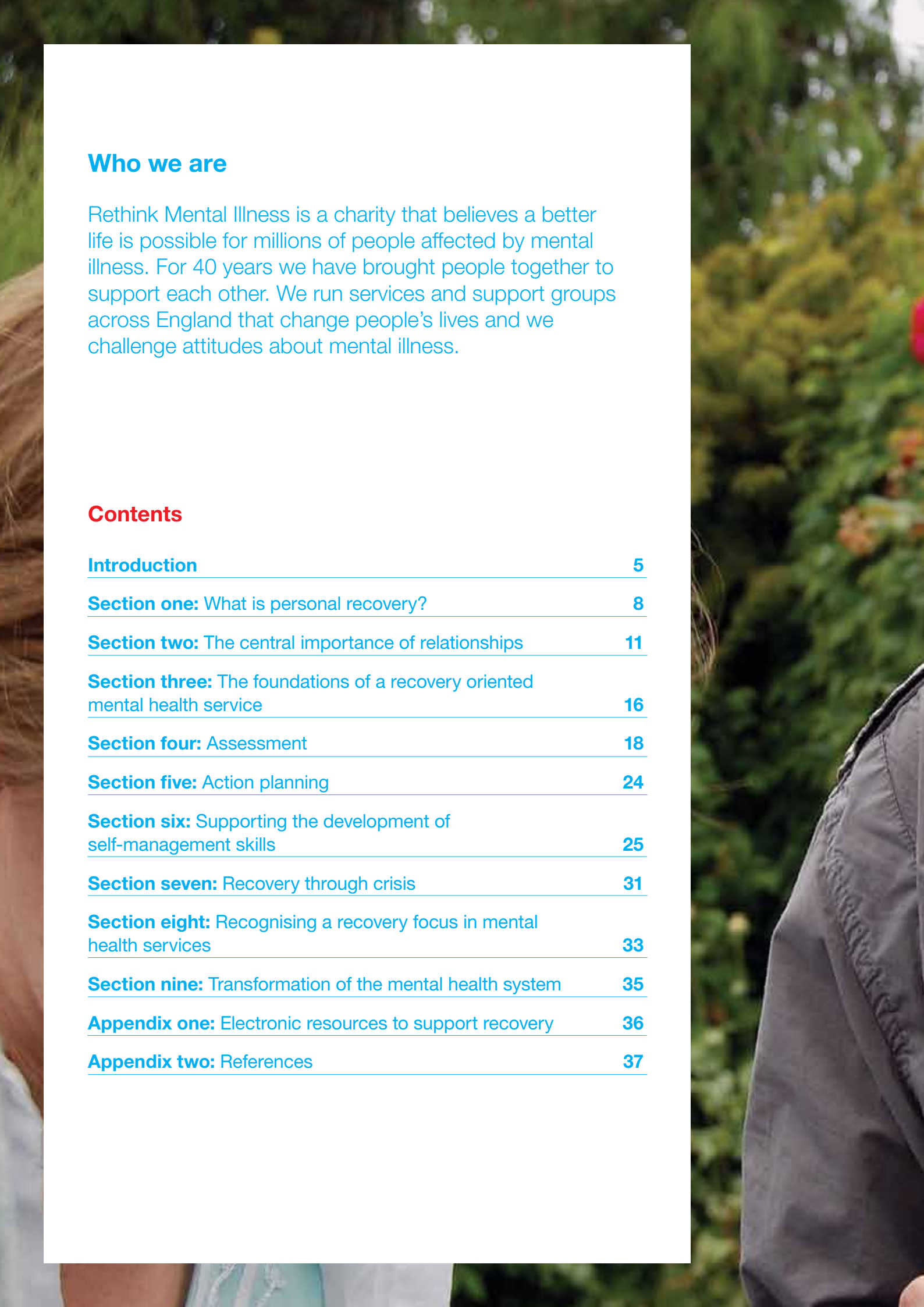
Rethink Mental Illness.

100 ways to support recovery.

A guide for mental health professionals

by Mike Slade

SECOND EDITION



Who we are

Rethink Mental Illness is a charity that believes a better life is possible for millions of people affected by mental illness. For 40 years we have brought people together to support each other. We run services and support groups across England that change people's lives and we challenge attitudes about mental illness.

Contents

Foreword

At Rethink Mental Illness we are working hard to improve the lives of people with mental illness, and reforming the way mental health services are run is key. This book offers 100 practical ways in which mental health staff can work in a person-centred and recovery-oriented way.

Since the first edition was published in 2009, it has been downloaded over 23,000 times from the Rethink Mental Illness website (rethink.org/100ways) and been translated into several European languages. This second edition references new emerging evidence and includes updated links to relevant resources.

Professor Mike Slade, the report author, is a consultant clinical psychologist with South London and Maudsley NHS Foundation Trust and a Professor of Health Services Research at the Institute of Psychiatry, King's College London. His team of researchers are in the final phase of their five year REFOCUS research trial (due to complete in 2014), which is developing and evaluating a manualised recovery intervention for use within adult mental health community based teams in England.

In the few years since the publication of the first edition, attention to mental health recovery has further matured. Recovery has become an integrated aspect of everyday practice in mental health service provision, and new policy-driven developments such as Personalisation and Personal Health Budgets have been introduced to support person-centred working.

But still much needs to be done. In 2012 the Schizophrenia Commission reported their findings based on a comprehensive review of current evidence and practice, and they identified areas that need improvement to make sure people get the support and treatment that will make a real change in people's lives (schizophreniacommission.org.uk). This updated second edition of *100 ways to support recovery* offers a practical tool for mental health staff to support this work.

Paul Jenkins
Chief Executive, Rethink Mental Illness
April 2013

Introduction

This is a guide for mental health staff, which aims to support the development of a focus on recovery within our services. It provides different ideas for working with service users* in a recovery oriented fashion.

It is written on the basis of two beliefs:

- First, recovery is something worked towards and experienced by the person with mental illness. It is not something services can do to the person. The contribution of staff is to support the person in their journey towards recovery.
- Second, the journey of recovery is individual. The best way of supporting an individual's recovery will vary from person to person.

Since there is no ideal or 'right' service, it is not possible to provide step-by-step instructions for how recovery can be supported by mental health staff. This guide therefore provides a map, rather than a turn-by-turn journey plan.

At the heart of this report is a conceptual framework to identify what types of support may be useful. It is called the Personal Recovery Framework and is based on the accounts of people who have personal experience of mental illness. Translating this framework into practice is the goal of this publication.

* Whilst recognising the term is contested, we refer to 'service users' because our focus is on people with personal experience of mental illness who are using services.

Second edition

Since the first edition of *100 ways to support recovery* was published in 2009, it has been downloaded over 23,000 times from the Rethink Mental Illness website (rethink.org/100ways).

Not much has changed since 2009 in our understanding of recovery which emerges from people's stories – living a life beyond illness remains possible for many people when active striving is accompanied by good support. However, a new evidence base is emerging in the academic mental health literature.

For example, the Section for Recovery at the Institute of Psychiatry has undertaken several recovery studies – see researchintorecovery.com for more information. This has included systematic reviews (the most rigorous method for synthesising evidence) which identified key recovery processes of Connectedness, Hope, Identity, Meaning and Empowerment (the CHIME Framework)[1], how to assess recovery[2], how to identify strengths[3], and how to increase hope[4].

It is now possible to identify best practice for mental health services in supporting recovery[5]. Measures to identify good recovery support have been evaluated[6], leading to the development of a new free measure called INSPIRE (researchintorecovery.com/inspire).

Interventions to support recovery are being developed[7] and evaluated[8], and national initiatives to transform mental health services are underway across England[9]. In all these developments, Rethink Mental Illness has been a guide and a partner. This second edition of 100 Ways to support recovery has been updated to reflect this emerging evidence base.

Mike Slade

Section one: What is personal recovery?

Recovery is a word with two meanings.

Clinical recovery is an idea that has emerged from the expertise of mental health professionals, and involves getting rid of symptoms, restoring social functioning, and in other ways 'getting back to normal'.

Personal recovery is an idea that has emerged from the expertise of people with lived experienced of mental illness, and means something different to clinical recovery. The most widely used definition of personal recovery is from Anthony (1993)[10]:

…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.

It is generally acknowledged that most mental health services are currently organised to meet the goal of clinical recovery. Yet mental health policy around the world increasingly emphasises support for personal recovery. For example, in England a central goal of the 2011 national mental health strategy was "More people with mental health problems will recover".[11] How do we transform services towards a focus on personal recovery? This report identifies 100 different ways, starting with a conceptual framework to underpin the transformation.

Box 1: Personal Recovery Tasks

Recovery task 1: Developing a positive identity The first task of recovery is developing a positive identity outside of being a person with a mental illness. Identity elements which are vitally important to one person may be far less significant to another, which underlines that only the person can decide what constitutes a personally valued identity for them.

Recovery task 2: Framing the 'mental illness' The second recovery task involves developing a personally satisfactory meaning to frame the experience which professionals would understand as mental illness. This involves making sense of the experience so that it can be put in a box: framed as a part of the person but not as the whole person. This meaning might be expressed as a diagnosis, or as a formulation, or it may have nothing to do with professional models – a spiritual or cultural or existential crisis (hence the quotes in the task title).

Recovery task 3: Self-managing the mental illness Framing the mental illness experience provides a context in which it becomes one of life's challenges, allowing the ability to self-manage to develop. The transition is from being clinically managed to taking personal responsibility through self-management. This does not mean doing everything on your own. It means being responsible for your own well-being, including seeking help and support from others when necessary.

Recovery task 4: Developing valued social roles The final recovery task involves the acquisition of previous, modified or new valued social roles. This often involves social roles which have nothing to do with mental illness. Valued social roles provide scaffolding for the emerging identity of the recovering person. Working with the person in their social context is vital, especially during times of crisis when support usually received from friends, family and colleagues can become most strained.

1.1 The Personal Recovery Framework

Supporting personal recovery involves moving away from a focus on treating illness and towards promoting well-being. This will involve transformation, in which professional models become part of a larger understanding of the person. This understanding can be guided by the Personal Recovery Framework which is based on the four domains of recovery that emerge from accounts of people who have lived with mental illness[12]:

- **Hope** as a frequent self-reported component of recovery
- **Self-identity**, including current and future self-image
- **Meaning** in life, including life purpose and goals
- **Personal Responsibility** – the ability to take personal responsibility for one's own life.

The Personal Recovery Framework (shown in Figure 1) is based on four recovery tasks commonly undertaken during recovery (shown in Box 1). These are loosely ordered, to suggest a general but not universal ordering from belief to action and from personal to social.

The arrows indicate that recovery involves minimising the impact of mental illness (through framing and self-managing) and maximising well-being (by developing a positive identity and valued social roles and relationships).

A personal recovery-oriented mental health service is organised to support individuals to undertake the four recovery tasks, underpinned by an emphasis on relationships. The central differences between recovery-oriented and traditional practice have been considered by several authors with experience of trying to implement pro-recovery service change[13-17], and some points of variation are shown in Table 1.

Figure 1: The Personal Recovery Framework

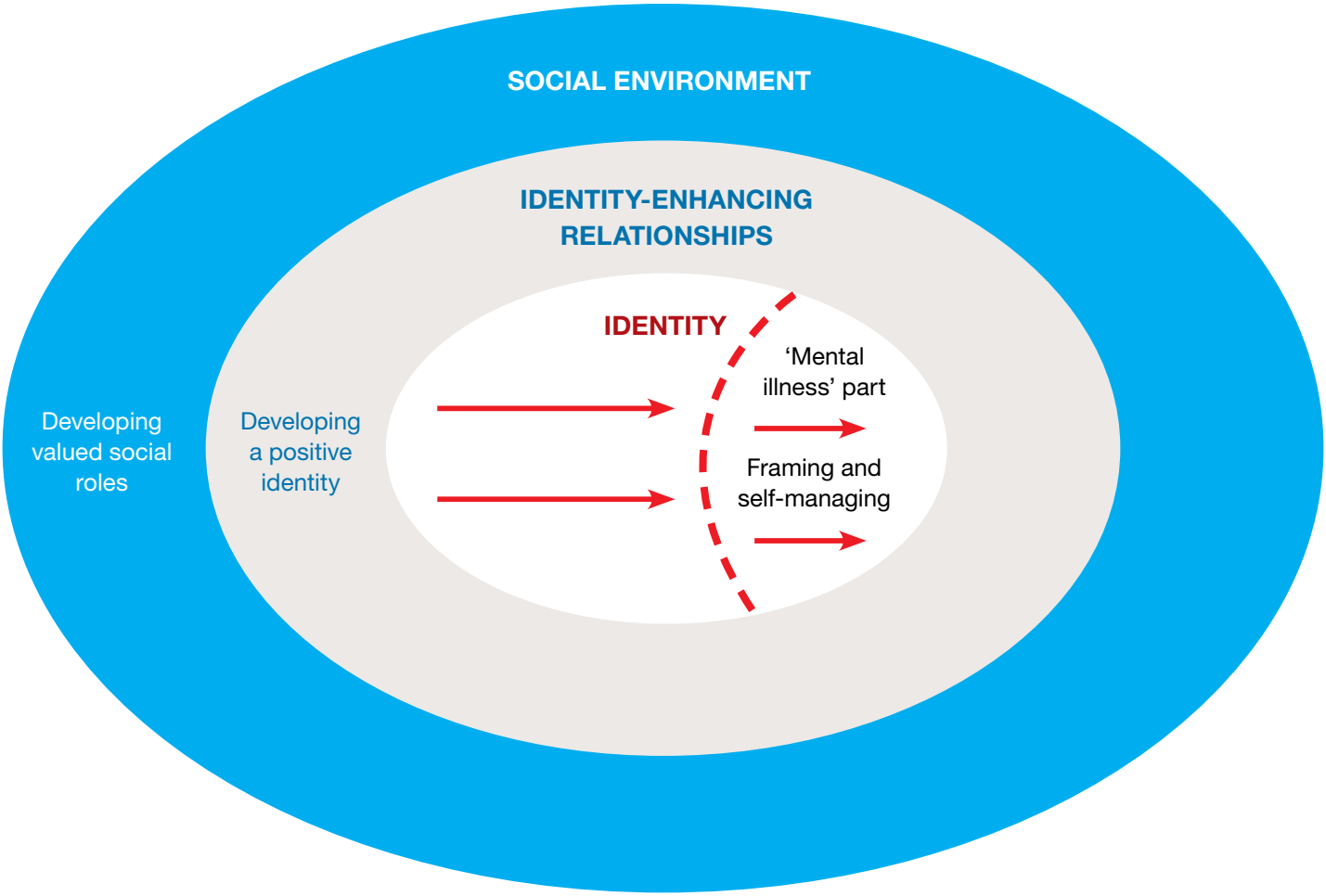


Table 1: Differences between traditional and recovery-oriented services

Traditional approach	Recovery approach
Values and power arrangements	
(Apparently) value-free	Value-centred
Professional accountability	Personal responsibility
Control oriented	Oriented to choice
Power over people	Awakens people's power
Basic concepts	
Scientific	Humanistic
Pathography	Biography
Psychopathology	Distressing experience
Diagnosis	Personal meaning
Treatment	Growth and discovery
Staff and patients	Experts by training and experts by experience
Knowledge base	
Randomised controlled trials	Guiding narratives
Systematic reviews	Modelled on role models
Decontextualised	Within a social context
Working practices	
Description	Understanding
Focus on the disorder	Focus on the person
Illness-based	Strengths-based
Based on reducing adverse events	Based on hopes and dreams
Individual adapts to the programme	Provider adapts to the individual
Rewards passivity and compliance	Fosters empowerment
Expert care co-ordinators	Self-management
Goals of the service	
Anti-disease	Pro-health
Bringing under control	Self-control
Compliance	Choice
Return to normal	Transformation

Since personal recovery is something the individual experiences, the job of staff is to support the person in their journey towards recovery. The remainder of this report describes what this means in practice.

Section two: The central importance of relationships

This section begins to detail the 100 ways mental health staff can support recovery. It focuses on relationships – with peers, with staff and with others.

2.1 Supporting peer relationships

People with their own experience of mental illness ('peers') can directly contribute to the recovery of others[18-20]. Meaningful peer involvement is associated with innovative recovery-oriented services internationally. There are three types of peer support for recovery.

1: Mutual self-help groups

Mutual self-help groups give primacy to lived experience, leading to structures based on the assumption that all participants have something to contribute.

2: Peer Support Specialists

The peer support specialist is a role in the mental system for which personal experience of mental illness is a job requirement. Creating peer support specialist roles brings four types of benefit.

1. For the peer support specialist, it is a job with all the benefits that follow from this. Their own lived experience is valued, which can be a transformative reframing of an illness experience. They give to others, which is an important component of healing. Self-management and work-related skills are consolidated.
2. For other staff, their presence leads to increased awareness of personal values. Interacting with peer colleagues challenges stigmatising them-and-us beliefs within services in a natural rather than forced way.
3. For other service users, exposure to peer support specialists provides visible role models of recovery – a powerful creator of hope. There may also be less social distance than with staff, leading to more willingness to engage with services.
4. For the mental health system, peer support specialists can be carriers of culture. There is often less need to train and maintain a pro-recovery orientation in recovered service users and ex-users, because of their own lived experience.

3: Peer-run programmes

A peer-run programme is more than simply an organisation staffed by people with lived experience of mental illness[18]. It is a service whose purpose is to promote personal recovery through its values and operating practices. Peer-run services have a very different feel to traditional mental health services: they directly communicate the message that the experience of mental illness is an asset. Their central goal is to support people to re-engage in determining their own future.

Action points

Staff can foster peer support by…

1. Collaborating with voluntary sector organisations to develop mutual self-help groups and actively promoting access to them

2. Distributing information written for service users about recovery[21-24]

3. Employing peer support specialists in the service, and supporting them to make a distinct contribution

4. Encouraging the development of peer-run programmes

5. Support people to talk about their own recovery stories, e.g. through training from professional story-tellers, by developing a local speaker's bureau, by encouraging service users to tell their stories in local and national media

6. Being familiar with electronic resources, e.g. www.mentalhealthpeers.com, www.recoveryinnovations.org

2.2 Relationships with professionals

In a recovery-oriented service, the service user is the ultimate decision-maker other than where legal issues over-ride. This does not always mean that staff do what the person says; clearly a worker cannot act unethically, or collude with an individual in damaging acts. But the basic orientation is towards actively seeking to be led by the individual. This means that a professional perspective is one potentially helpful way of understanding the person's experiences, but not the only possible way.

A term used to describe this type of partnership relationship is **mutuality** – the view that we have all recovered from challenges, and that it is helpful to emphasise this commonality. The recovery worker is prepared to work alongside and therefore be more exposed to the person, and sees their job as providing choices rather than fixing the problem. They may also be challenged, influenced and changed by the service user.

Sometimes staff will need to make decisions for the service user. People do temporarily lose their ability to look after themselves, and in the absence of any better option need staff to provide guidance and to intervene, with compulsion when necessary. It is unhelpful to put expectations on a person who is still early in their recovery journey (what a professional might call acutely unwell) which they cannot even begin to meet. Similarly, sometimes people want a professional view – about diagnosis, prognosis and treatments. Service users who want to understand their experiences as a mental illness have a right to know the worker's opinion about what is wrong with them and what might help.

A specific communicating style which is prominent in a recovery-oriented service is coaching. The advantages of a **coaching** approach are:

1. It assumes the person is or will be competent to manage their life. The capacity for personal responsibility is a given.

2. The focus is on facilitating the process of recovery to happen, rather than on the person. Coaching is about how the person can live with mental illness, and differs from the traditional focus on treating the mental illness.

3. The role of the coach is to enable this self-righting capacity to become active, rather than to fix the problem. This leads to amplification of strengths and existing supportive relationships, rather than of deficits.

4. Effort in the coaching relationship is directed towards the goals of the coachee, not the coach. The skills of the coach are a resource to be offered. Using these skills is not an end in itself.

5. Both participants must make an active contribution for the relationship to work.

Action points

Staff can support recovery by:

7. Attaching at least as much importance to the wishes and preferences of the service user as to their own views
8. Wherever possible, being led by the priorities of the service user rather than the staff
9. Being open to learning from, and being changed by, the service user
10. Wherever possible, using coaching skills
11. Giving and receiving supervision which considers the relationship as well as technical intervention competencies

Professional expertise remains central, although it is deployed to support self-management. This shift towards partnership relationships is not then a licence for staff to work less hard, or to abandon more easily, or to provide unfocussed or non-evidence based treatment. It involves the use of professional expertise in a different way, in which the processes of assessment, goal-planning and treatment all support recovery.

2.3 Supporting other relationships

People need not only to recover from mental illness itself, but from its emotional, physical, intellectual, social and spiritual consequences. Connection with others and actively engaging in life are important sources of well-being. Many people in recovery identify that having some form of faith is an important support when they feel abandoned by others.

Action points

Staff can encourage spirituality and connection with others by:

12. Asking the person about meaning and purpose in their life. This may be stepping outside the worker's sphere of knowledge, but may also be stepping into the person's sphere of need
13. Nurturing a positive view of the self, by demonstrating compassion in their response to a service user who reports setbacks
14. Supporting access to spiritual experiences, e.g. scripture, prayer, attending places of worship, accessing on-line religious resources
15. Supporting access to uplifting experiences, e.g. art, literature, poetry, dance, music, science, nature
16. Supporting access to opportunities for self-discovery, e.g. personal therapy, keeping a diary, writing a poem or a song, developing a narrative about oneself
17. Helping the person to give back to others, e.g. encouraging voluntary work, having a pet, having responsibility for something or someone
18. Being familiar with electronic resources, e.g. www.spiritualcrisisnetwork.org.uk, www.spiritualcompetency.com
19. Encouraging the person to develop social capital, e.g. by experiencing citizenship, becoming politically active (including as a user-activist)
20. Encouraging the person to engage in cultural activity, e.g. by accessing culture-specific groups, through healing and purifying cultural ceremonies
21. Creating time for the person to think, including a quiet place to go, and prompts which aid contemplation

Section three: The foundations of a recovery-oriented mental health service

Working in a recovery-oriented way starts with a consideration of **values**. A consistent theme in services which have developed expertise in relation to recovery is that values are both explicitly identified and used to inform daily decision-making.

This requires three processes:

- making values explicit
- embedding them in daily practice
- and tailoring practice using performance feedback

The first process is to **make values explicit**, and hence amenable to debate. This involves identifying and making visible the permeating organisational values in a live, rather than paper-based, way. What are the guiding values of a recovery-oriented mental health service? They don't have to be complex. Bill Anthony has proposed[25]:

People with severe mental illnesses are people.

This provides a fundamental orientation for mental health services. People with mental illness want all the normal entitlements, roles and responsibilities of being a person. The task of mental health services is to support progress towards these goals.

This single principle is a helpful summary for those people who easily connect with recovery values, but many workers will find an expanded approach more helpful. A proposal for core values is shown in Box 2.

Box 2: Proposed values for a recovery-oriented mental health service

Value 1

The primary goal of mental health services is to support personal recovery

Supporting personal recovery is the first and main goal of mental health services.

Value 2

Actions by staff will primarily focus on identifying, elaborating and supporting work towards the person's goals

If people are to be responsible for their own life, then supporting this process means avoiding the imposition of meanings and assumptions about what matters, and instead focussing on the person's life goals.

Value 3

Mental health services work as if people are, or (when in crisis) will be, responsible for their own lives

It is not the job of staff to fix people, or lead them to recovery. The primary job is to support people to develop and use self-management skills in their own life. The instinctive response of staff to any situation needs to be "*You can do it, we can help*":

- *You can do it* because of a genuine belief in the immense potential for self-righting and taking personal responsibility within each person and their wider community
- *We can help* because of a simultaneous belief that professional expertise has high value for many people, especially when Value 2 is present

These values point to the need for a balance away from taking responsibility for and towards taking responsibility *with* the person. Taking responsibility with the person means explicitly negotiating and collaborating within a partnership relationship, holding a rapidly reducing share of responsibility as the focus moves as soon as possible from doing to (during crisis), through doing with, to the person doing for themselves. It also involves values-awareness by the worker – a self-knowledge about personal and professional values.

The second process is to **embed values into the daily life and working practices of the mental health system**. This is a major challenge, since training in values does not easily impact on practice.

The third process involves **tailoring practice through performance feedback**. Without good information about success, the natural tendency is to assume all is well (or, at least, to focus attention on the many other pressing demands).

Action points

Staff can support recovery by:

22. Learning about recovery, from websites (see Appendix), recovery narratives[26-30], and meeting people in recovery

23. Making values explicit within the organisation

24. Owning and widely publicising these values with all stakeholders

25. Expecting to be held accountable to these values

26. Creating a culture of empowerment rather than compliance within the mental health workforce, so workers do not 'need permission' to shape behaviour towards the agreed values

27. Collecting information about performance against these values, and changing behaviour to improve performance

28. Organisational transformation, e.g. actively promoting – literally if possible – recovery champions, joining existing networks (e.g. Coalition of Psychiatrists in Recovery – www.wpic.pitt.edu/AACP/CPR), learning from others

29. Recruiting people with recovery competencies[31;32;24], by interviewing with questions such as "Why do you suppose people with mental illness want to work?" to give a chance for applicants to demonstrate their values, assessing whether key knowledge, attitudes and skills about recovery[33] are present

Section four: Assessment

How can assessment promote recovery? The aims of assessment differ from the traditional goal of identifying the illness and planning the treatment.

4.1 Using assessment to develop and validate personal meaning

The development of personal meaning is central to recovery, but few find anything fulfilling in the role of a mental patient. How can staff assess the person in a way that avoids imposing negative meaning and hence getting in the way of recovery?

The Personal Recovery Framework identified the central distinction between the person experiencing the mental illness and the mental illness itself, and the consequent importance of a primary focus on the person, not the illness.

For the person experiencing mental illness, integration of the experience into their overall identity is an important step on the journey of recovery. It cannot be done to the person, so assessment involves working with the person to help them develop their own explanation.

The process normally starts with the quest for meaning – making sense of what has been, and is, happening. Many people will try to reduce anxiety by wanting an answer from the mental health professional. Therefore part of the assessment will involve collecting enough information to be able to offer a professional perspective. The professional view about diagnosis should certainly be shared, but there should also be a tentativeness in how it is used in the assessment process. It is a resource to offer to the service user, not 'the' answer.

Being given a diagnosis can be helpful, for example in showing that others have experienced similar things. But it can also be unhelpful if either the worker or the service user think a diagnosis is an explanation (when it is a description), and it can actively impede recovery if the person expects the professional, who now knows what's going on, to cure them.

For many, perhaps most, people with mental illness, there is no magic bullet, despite what they may hope for. The reality is that recovery involves innumerable small acts. Tentativeness in communicating a professional perspective therefore needs to be genuine, rather than a therapeutic manoeuvre to soften the blow of diagnostic reality.

The outcome of the individual's quest for meaning may or may not be consistent with a professional perspective. It doesn't matter! The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human[34].

Action points

Staff can support the development of personal meaning by:

30. Incorporating research into the meaning of life[35] into their work
31. Developing new scripts which validate personal meaning, e.g. responding to "I have schizophrenia" with "I'm wondering if that's what you think or what other people have said about you?"
32. Experiencing interactions with people experiencing mental health problems outside of a clinical context, such as meeting voice-hearers who accept the voices as being real through the Hearing Voices Network or Intervoice (www.intervoiceonline.org), or by developing psychosis seminars[36], or as colleagues in user-employee roles
33. Understanding that the relationship between the voice-hearer and their voice is a social relationship[37], and so issues of victimhood, power, fear and empowerment are valid assessment topics

4.2 Using assessment to amplify strengths

Up close, nobody is normal. Asking only about deficits will give a biased picture of the individual, as having few strengths and personal or social resources. How can assessment amplify strengths as well as identify difficulties?

One approach is to develop a structured dialogue, equivalent to a mental state examination, to identify a person's strengths, values, coping strategies, dreams, goals and aspirations. What might this look like? In Box 3 a Mental Health Assessment is proposed, with the equivalent elements from a standard history-taking interview shown in square brackets.

Action points

Staff can support the development of a positive identity by:

34. Assessing capabilities as well as disabilities, by assessing strengths, or by using the questions in Box 3, or by implementing the Strengths Model[38], or by using the Values in Action Inventory of Strengths (online questionnaire at www.viastrengths.org)[39], or the Rethink Mental Illness Physical health check (www.rethink.org/physicalhealthcheck)

4.3 Using assessment to foster personal responsibility

The goal of assessment is to create a partnership relationship which amplifies the individual's efforts towards recovery. The challenge is to get out of the way of the person's recovery, by avoiding dependency-creating relationships, deficit-focussed assessments, doing-to treatments, and drip-feeding responsibility back to the person. What practical difference does this orientation make?

One example is in goal-setting activity. Many people experience difficulty in developing purposive activity. Staff can support this by using person-centred questioning:

- When have you most felt alive?
- When did you last have fun?
- What would make a difference in your life?
- What are your dreams?
- What do you want in life?
- What would make your life better?
- What would give your life more meaning?
- What would make your life more enjoyable?

The challenge is then *not* to get in the way by assuming responsibility, for example through helping the client to decide whether the goal is realistic, or identifying *for the person* the steps towards their goal.

The antidote to any professional tendency to assume responsibility is to use coaching skills for supporting partnership relationships: "What would it take to meet this goal?", "What would happen if you challenge the rule that says you're not allowed to do that?" Workers need expertise in facilitating as well as doing.

Box 3: Mental Health Assessment

Current strengths and resources [History of the presenting illness]
What keeps you going? Consider spirituality, social roles, cultural / political identity, self-belief, life skills, toughness, resilience, humour, environmental mastery, support from others, ability to express emotion artistically.

Personal goals [Risk assessment]
How would you like your life to be different? What are your dreams now? How have they changed?

Past coping history [Past psychiatric history]
How have you got through the tough times in your life? What supports have you found useful? What do you wish had happened?

Inherited resources [Genetic background]
Is there any history of high achieving in your family? Any artists, authors, athletes or academics?

Family environment [Family environment]
When you were growing up, was there anyone you really admired? What important lessons did you learn during childhood?

Learning from the past [Precipitating events]
What have these experiences taught you? Are there any positive ways in which you have changed or grown as a person? Consider gratitude, altruism, empathy, compassion, self-acceptance, self-efficacy, meaning.

Developmental history [Developmental history]
What was life like for you when you were growing up? What did you enjoy? What's your best memory? What skills or abilities did you discover you had?

Valued social roles [Occupational history]
What would someone who knew you really well and liked you say about you? What would you like them to say? How are you useful or of value to others?

Social supports [Relationship history]
Who do you lean on in times of trouble? Who leans on you?

Personal gifts [Forensic history, drug and alcohol]
What is special about you? Has anyone ever paid you a compliment? What things that you've done or ways that you've behaved make you feel really proud of yourself?

A positive identity also emerges from healthy living, eating and fitness – or anything that makes people feel good about themselves.

4.4 Using assessment to support a positive identity

Staff know that the experience of mental illness will almost certainly change the person. Changes in identity during personal recovery are as individual as any other recovery process. However, two broad types of change can be distinguished: redefining existing elements of identity (identity re-definition) and developing new elements (identity growth). Recovery-oriented workers know that this identity work begins as soon as possible: focussing solely on cure of the mental illness gets in the way of supporting people to live good lives now.

Action points

Staff can support the development of a positive identity by:

35. Finding ways of seeing the person when the illness is very prominent, e.g. using time-lines to help put the person as they are now into the broader context of their own life, increasing involvement with the person when well so that the worker can hold a picture of the well person during crisis, involving carers

36. Learning from non-mental health approaches to amplifying a positive identity (e.g. www.bluesalmon.org.uk)

37. Working together to find an explanation which is helpful to the service user

38. Focussing discussion on the person not the illness: including well-being and capability and preferences as well as symptoms and disability

4.5 Using assessment to develop hope

Change at the level of identity is a frightening prospect, and hope that recovery is possible may be vital. How can this hope for the future be realistically supported, when we cannot know what the future holds for an individual? It is possible to identify values, attitudes and behaviours in staff which promote hope in the people they work with[40-42].

Strategies for promoting hope are shown in Table 2.

Action points

Staff can support the development of hope by:

39. Using the strategies listed in Table 2

40. Using every meeting as an opportunity to help the service user to learn more about themselves

41. Showing modesty and tentativeness about the limits of professional knowledge

42. Talking about recovery

Table 2: Strategies for promoting hope

	Using interpersonal resources	Activating internal resources	Accessing external resources
Staff values	Valuing the person as a unique human being	Failure is a positive sign of engagement, and contributes to self-knowledge	Target efforts towards supporting the person to maintain relationships and social roles
	Trust in the authenticity of what the person says	To be human is to have limitations – the challenge is to exceed or accept them	Find or build an audience to the person's uniqueness, strengths and best efforts
Staff attitudes	Believing in the person's potential and strength	Losses need to be grieved for	Housing, employment and education are key external resources
	Accepting the person for who they are	The person needs to find meaning in their mental illness, and more importantly in their life	Employ recovered service users and ex-users in services as role models
	View set-backs and 'relapse' as part of recovery		
Staff behaviours	Listening non-judgementally	Support the person to set and reach personally valued goals	Facilitate contact with peer role models and self-help groups
	Tolerate the uncertainty about the person's future	Support the person to develop better approaches to coping	Be available in crisis
	Express and demonstrate a genuine concern for the person's well-being	Help the person to recall previous achievements and positive experiences	Support access to a full range of treatments and information
	Use humour appropriately	Support and actively encourage exploration of spirituality	Support close relationships

Section five: Action planning

In a mental health service focussed on personal recovery, assessment leads to the identification of two types of goal.

Recovery goals are the individual's dreams and aspirations. They are influenced by personality and values. They are unique, often idiosyncratic. They are forward-looking, although they may of course involve the past. They are based on what the person actively wants, rather than what the person wants to avoid. Recovery goals are strengths-based and oriented towards reinforcing a positive identity and developing valued social roles. They can be challenging to staff, either because they seem unrealistic, inappropriate, or supporting them is outside their role. They sometimes involve staff effort, or they may have nothing to do with mental health services. They always require the service user to take personal responsibility and put in effort. Recovery goals are set by the service user, and are dreams with deadlines.

Treatment goals arise from the societal requirements and professional obligations imposed on mental health services to constrain and control behaviour and improve health. These goals will normally be about minimising the impact of an illness and avoiding bad things happening, such as relapse, hospitalisation, harmful risk, etc. The resulting actions will often be doing-to tasks undertaken by staff. Treatment goals and associated actions provide the basis of defensible practice, and are important and necessary.

Recovery goals and treatment goals are different. Recovery goals look like the goals of people with no mental illness. Identifying recovery goals needs to be an explicit focus within the assessment process.

Action points

Staff can help the person identify recovery goals by:

43. Using person-centred planning[43;44]

44. Supporting the use of user-developed work-books[45;46]. Wellness Recovery Action Planning (WRAP)[47] is the most widely used approach internationally (www.mentalhealthrecovery.com)

45. Completing a personal WRAP – identifying something from which the worker is recovering promotes experiential learning and reduces stigmatising distinctions

Section six: Supporting the development of self-management skills

Staff support recovery by offering treatments and interventions which amplify the person's self-management skills. Access to competently-provided effective treatments is a vital support for many people's recovery, but providing treatment is not the primary purpose of mental health services. A recovery-oriented service supports people to use medication, other treatments and services as a resource in their own recovery.

Recovery is supported where the person experiences the resulting treatment as person-centred, enhancing of natural supports, strengths-based and community-focussed. The challenge is to work with the person: services on tap, not on top.

Action points

Staff can support self-management by:

46. Creating a pleasant and respectful welcoming environment – displaying stories of recovery, providing fresh fruit and drinks

47. Attending to the first personal contact. For example, club-houses hire greeters to welcome new members, and The Living Room in-patient service (www.recoveryinnovations.org) employs peer triage workers so the first contact of someone in crisis is with another person with lived experience of mental illness who is in recovery

6.1 Supporting the development of agency

A necessary requirement for self-management is a sense of agency: a self-belief that the person can impact on their own life. It can be a difficult process precisely because mental illness often takes away one's self-belief. Asking someone to take responsibility for their lives before they have that capacity will not benefit the person. This is not making the case for low expectations – people do often rise to the challenge. It is making the case for support which fits the person's stage of recovery.

Action points

Staff can support the development of agency by:

48. Using personal experiences of life plans needing to change, to increase self-awareness about how difficult agency can be

49. Supporting goal-striving

50. Setting the person up to experience achievement

51. Encouraging the person to give back to others

52. Supporting access to experiences of pleasure

53. Amplifying personal success, and aiding the integration of positive experiences into personal identity

6.2 Supporting the development of empowerment

Empowerment emerges from agency beliefs and involves behaviours which impact positively on one's life. The traditional approach has been to view the person as the problem. The fundamental shift in a recovery perspective is to see the person as part of the solution. A recovery-oriented approach assumes the person has capacity to take responsibility for their life. The question then moves away from how the worker can stop the damaging behaviour, and becomes how to support the person to get to a point where they want to stop.

The WIIFM Principle motivates the behaviour of most people – What's In It For Me? The challenge is to identify what personally-valued recovery goal is being undermined by the behaviour. If this proves impossible, then the behaviour (such as disengaging from services which are not targeting the individual's goals) may be entirely rational and nothing to do with illness.

Action points

Staff can support the development of empowerment by:

54. Getting the complaints procedure in place and working

55. Offering the option to change staff

56. Supporting access to self-management resources (e.g. www.glasgowsteps.com)

57. Fostering exposure to people in recovery who can model empowerment and demonstrate experience in self-managing

58. Advocating for employers to give positive credit for experience of mental illness[48]

59. Supporting user-led evaluation of treatments and services

60. Giving training in assertiveness (e.g. by teaching the DESC script[49]) and then reinforcing empowerment behaviours

61. Validating efforts to self-manage through non-mental health types of help, such as spiritual support or a cultural ceremony

62. Practising fostering empowerment by allocating a 'recovery hat' to an individual in each team meeting. That worker's role is then to be an advocate for the service user being discussed, with their input focussed on how services are supporting the individual's recovery

63. Viewing resistance to change as reasonable, understandable and normal, because recovery happens in stages

6.3 Supporting the development of motivation

The approach of motivational interviewing addresses how to initiate movement towards recovery goals[50]. Motivational interviewing is a person-centred approach to supporting changes in behaviour through the exploration and resolution of ambivalence, and is oriented towards collaboration, evocation and autonomy.

Action points

Staff can increase motivation by:

64. Using reflective listening to test the hypothesis about what is heard against what is meant: “It sounds like you…”, “You’re feeling…”, “So you…”
65. Focussing on why the person might want to change, not how they will change
66. Focussing on pro-change motivations: “Think of your recovery goal. Rate readiness to change behaviour towards the goal on a scale from 1 (not ready) to 10 (fully ready). What made your rating more than 1?”
67. Undershooting, e.g. “So your cutting doesn’t cause any problems at all for you?”
68. Overshooting, e.g. “So it seems like there’s no chance whatsoever you’ll be able to meet your goal?”
69. Questioning to increase motivation – “What makes you think you can do it?”, “If you succeed, how will things be different?”, “What were you like before the problem emerged?”, “What worries you about this situation?”, “What’s the worst that could happen if you don’t make a change?”
70. Exploring values – “What are the most important things in your life?” – and noting behaviour-value contradictions
71. Creating celebration rituals to amplify and sustain success

6.4 The contribution of medication to recovery

In a recovery-oriented mental health service, a full range of psychotropic medication may be available. However, the job of the service is not to get medication taken, whatever the cost. The job, of course, is to support personal recovery. This may or may not involve use of medication for an individual at a particular point in their life. So medication – with its balance of positive and negative effects – is one potential recovery support, among many.

Action points

Staff can support the use of medication as a recovery tool by:

72. Placing central importance on the person taking personal responsibility for their well-being

73. Viewing medication as an "exchangeable protection against relapse"[51], in which pharmacological and psychosocial approaches both buffer the individual against relapse. Focussing on promoting resilience (which definitely matters) rather than on medication (which may or may not matter). See www.resilnet.uiuc.edu for more on resilience.

74. Using expertise about medication to help the person come to the best choice for them

75. Giving control about medication to the service user, recognising that 100% prescribing rates raise the question of whether choice really is available

76. Ensuring that prescribed medication is fully available for all who want it

77. Supporting people who are uncertain about taking medication, through crystallising questions, focussing discussion on the contribution of medication to recovery goals, providing unbiased information (including about side-effects), and supporting the person to plan and undertake experiments

78. Learning from innovative approaches to supporting decision-making about medication in general medicine (e.g. www.dhmc.org/shared_decision_making.cfm, http://decisionaid.ohri.ca/index.html) and in mental health services, e.g. CommonGround (patdeegan.com)

79. Supporting people who want to come off medication, e.g. by giving information about advantages and disadvantages, identifying alternatives (continuing with medication for a fixed period and then re-reviewing, identifying early warning signs and joint crisis plans before stopping, graded withdrawal, etc.), validating their decision even where it differs from the prescriber's view, and identifying non-medication sources of support

80. Being familiar with the resources[52-56] and websites (e.g. www.comingoff.com) which are becoming available to support people who want to come off their psychiatric medication.

6.5 The contribution of risk-taking to recovery

An important issue raised by a shift towards individuals having responsibility for, and control over, their own lives is risk. Political and professional reality influences the mental health system towards risk avoidance. This matters, because people need to take risks to grow, develop and change. In life, taking risks is a necessary part of being human. The conflation of these two uses of the term risk – something necessary and something to avoid – is unhelpful. In a recovery-oriented service, there is a clear separation of the two meanings.

Harmful risk relates to behaviours which are illegal or not socially sanctioned, e.g. homicidal and suicidal acts, anti-social and criminal behaviour, personal irresponsibility, self-harming patterns of behaviour and relapse of mental illness. Harmful risk is to be avoided, and treatment goals focus on reducing harmful risk. Avoidance of harmful risk can also be part of a recovery goal, although this is avoidance for a reason: "My voluntary work means such a lot to me that I want to avoid threatening it through becoming hostile when I am unwell".

Positive risk-taking relates to behaviours which involve the person taking on challenges leading to personal growth and development. This includes developing new interests, trying something you're not sure you can achieve, deciding to act differently in a relationship, and taking on new roles. There is nearly always benefit from this – even if it all goes wrong, resilience is developed through trying and failing. Positive risk-taking – risk for a reason – will be needed to meet many recovery goals.

Action points

Staff can support recovery in relation to risk by:

81. Being aware that a focus on harmful risk avoidance through staff action creates a culture which may in fact reduce the extent to which people develop skills at taking responsibility for their own actions

82. Recognising that engagement with mental health services is much more likely if recovery goals rather than treatment goals are given primacy

83. Ensuring audited and organisationally-supported systems are in place to assess, develop and document actions involving positive risk-taking in the service of recovery goals

84. Focussing on positive risk-taking rather than on avoiding harmful risk, because this is what develops risk self-management skills

85. Identifying actions to reduce harmful risks as far as possible collaboratively with the service user

Section seven: Recovery through crisis

Compulsory treatment during crisis is sometimes necessary in recovery-oriented mental health services. For someone who is at risk of harming themselves or others, it is better for services to intervene – a focus on personal recovery is not a charter to stand back and let tragedies happen because the person didn't ask for or want help. So compulsion during crisis is acceptable, if other options have been exhausted.

A recovery-oriented approach to crisis aims to:

- prevent unnecessary crises
- to minimise the loss of personal responsibility during crisis
- and to support identity in and beyond the crisis

7.1 Preventing unnecessary crises

The best way of reducing the likelihood of a crisis is through the development of self-management skills. These lead to agency, empowerment, and the resilience to cope with set-backs. An important type of self-management skill is the ability to recognise and respond to the symptoms of mental illness. The challenge in relation to recovery is to undertake early warning signs work in a way which enhances the person's ability to self-right, rather than creating anxiety about, and over-vigilance for, relapse.

Skills are needed to communicate two messages. First, not all of life's bumps are indicators of potential relapse. At least as much effort needs to go into supporting the development of the skills to engage in life and an attitude of being able to deal with (rather than avoid) adversity.

Second, relapse (in the sense of going backwards) is normal. People struggling to break free from previous behaviour or emotional patterns experience set-backs. It may be helpful to communicate that most abstinent smokers have made 12-14 previous quit attempts[57], or that on average millionaires have experienced bankruptcy or near bankruptcy 3.2 times[58]. Positive risk-taking and the associated set-backs are necessary in life – they are a sign of health, not illness.

Action points

Staff can support people before crisis by:

86. Working with the service user to identify their early warning signs of a pending crisis

87. Communicating normalising messages about what constitutes a helpful level of self-monitoring

88. Emphasising that set-backs are normal – it is the response to the set-back that is critical

7.2 Minimising loss of personal responsibility during crisis

A recovery-oriented service aims to make as few decisions for the person as possible. This is done by keeping the process of decision-making as close to the person as possible. Ideally, people make their own decisions. Where they have temporarily lost this ability, their previously elicited views are used, or proxy decision-makers make decisions on their behalf. Only where these avenues are not available should workers make decisions in the person's best interests. A key approach to reducing loss of autonomy is therefore the use of advance directives. They take many forms, and their legal standing varies by country, but used appropriately they give the information staff need to do their job – which is keeping the person and their values centre-stage during crisis.

Action points

Staff can minimise loss of personal responsibility during crisis by:

89. Aiming to keep the person and their values centre-stage during crisis

90. Routinely using advance directives and other approaches (e.g. shared care agreements, patient-held records) in advance of crisis

7.3 Supporting identity in and through crisis

Relationships are of paramount importance during crisis. The traditional service response to a person presenting in crisis has been hospitalisation, and the importance of developing partnership relationships in recovery-oriented in-patient services is becoming clear. New types of alternative short-term residential services for people in crisis are also becoming available, such as Rethink Mental Illness' Cedar House in Rotherham.

Action points

Staff can support identity during crisis by:

91. Balancing the need for safety with the opportunity that being in crisis presents an opportunity to learn from the past and to re-orientate future plans

92. Keeping the person's normal life on the go: ensuring mail is collected, pets are fed, dependents cared for, bills paid, home secured, deliveries cancelled, etc.

93. Maximising engagement from the person's support network, e.g. by having unlimited visiting hours, actively encouraging visitors, involving them in meals and other unit activities

94. Keeping life skills activated. If the person is able to cook for themselves (and others), it is unhelpful for meals to be automatically provided. If the person enjoys reading or exercise (or any other form of personal medicine[59]), these are important to encourage

95. Reinforcing an identity as a person from the first contact, rather than starting with illness-focussed admissions procedures. Talking with the person about their life, what they want from admission, what they hope to do after, etc.

96. Supporting the person, over time, to reflect on and make sense of their crisis. How did it arise? What is good and bad about it? What learning does it contain? What plans or goals or supports or skills will the person need in the future?

97. Using time strategically, rather than providing a compulsory programme of activities. Individualising the support to the needs of the individual. This may simply involve giving the person space, or providing counselling to support recovery processes, or giving access to artistic media and therapies to allow the expression of experience

Section eight: Recognising a recovery focus in mental health services

How can we recognise a recovery focus in mental health services? There is as yet no accreditation process to identify a recovery focus in services, although best practice is becoming clear.

Tools to support services are now beginning to emerge:

- The INSPIRE measure is a service user-rated measure of recovery support received from a mental health worker. It can be downloaded for free from researchintorecovery.com/inspire
- The most widely used quality standards are the *Practice Guidelines for Recovery-Oriented Behavioral Health Care*[60;61]
- A fidelity measure for peer-run services called Fidelity Assessment Common Ingredients Tool (FACIT)[62]
- A measure to inform service development called the Pillars of Recovery Service Audit Tool (PoRSAT)[63]
- A service user-rated measure of the extent to which relationship supports recovery processes called the Recovery-Promoting Relationships Scale[64]

How can we evaluate the impact of a mental health service in ways which promote a focus on recovery? Outcome evaluation should be based on a theoretical framework, and should measure what matters. The Personal Recovery Framework provides a theoretical basis for outcome assessment. It identifies two classes of outcome which matter: valued social roles which reinforce social identity, and recovery goals which contribute to personal identity. An overall outcome evaluation strategy would measure these two things. First, objective quality of life indicators such as adequacy of housing, friendship, safety, employment, close relationships, income, etc. Second, progress towards personal goals. Meet these and you are likely to be a recovery-oriented mental health service.

Action points

Staff can make recovery outcomes more visible by:

98. Using recovery-supporting quality standards and service development tools

99. Assessing recovery process and outcome measures, e.g. using the INSPIRE measure (free from researchintorecovery.com/inspire)

100. Routinely monitoring and publicising attainment of socially valued roles and personally valued recovery goals

Section nine: Transformation in the mental health system

Working in a recovery-oriented way may not come naturally to the mental health system. Evolving towards a recovery vision may prove impossible without fundamental transformation.

Indeed, arguing for a focus on personal recovery *is* arguing for a paradigm shift, in which:

1. The intellectual challenge emerges from outside the dominant scientific paradigm (the understanding of recovery emerges from people who have experienced mental illness, not from mental health workers)
2. Previous preoccupations (e.g. risk, symptoms, hospitalisations) become seen as a subset or special case of the new paradigm
3. What was previously of peripheral interest (i.e. the 'patient's perspective') becomes central

A reversal of some traditional assumptions is at the heart of a recovery approach:

- The experience of mental illness is a part of the person, rather than the person being a mental patient or, for example, 'a schizophrenic'
- Having valued social roles improves symptoms and reduces hospitalisation, rather than treatment being needed before the person is ready to take on responsibilities and life roles
- The recovery goals come from the service user and the support to meet these goals comes from staff among others, rather than treatment goals being developed which require compliance from the service user
- Assessment focuses more on the strengths, preferences and skills of the person than on what they cannot do
- The normal human needs of work, love and play do apply – they are the ends to which treatment may or may not contribute
- People with mental illness are fundamentally normal, i.e. like everyone else in their aspirations and needs
- People will over time make good decisions about their lives if they have the opportunity, support and encouragement, rather than being people who will in general make bad decisions so staff need to take responsibility for them.

The implications for both service users and staff of embarking on a recovery journey are profound. It most obviously has the potential to empower and transform service users. However, the change does not stop there. A recovery approach also has the potential to liberate mental health staff from unmeetable expectations: diagnose this person; treat this illness; cure this patient; manage risk effectively; keep the public safe; exclude deviance from society. A focus on recovery is in the interests of all.

Appendix one:
Electronic resources to support recovery

General recovery resources

Rethink Mental Illness	www.rethink.org
Mental Health Commission	www.mhc.govt.nz
Boston University Center for Psychiatric Research	www.bu.edu/cpr
Ohio Department of Mental Health	www.mhrecovery.com
National Empowerment Center	www.power2u.org
Scottish Recovery Network	www.scottishrecovery.net
Recovery Devon	www.recoverydevon.co.uk
Section for Recovery, Institute of Psychiatry	www.researchintorecovery.com
Yale Program for Recovery and Community Health	www.yale.edu/prch

Specific recovery-oriented approaches

Intentional Care	www.intentionalcare.org
Tidal Model	www.clan-unity.co.uk
Intentional Peer Support	www.intentionalpeersupport.org
Wellness Recovery Action Planning (WRAP)	www.mentalhealthrecovery.com
The Village	www.mhavillage.org
Intervoice	www.intervoiceonline.org
Promoting Resilience	www.resilnet.uiuc.edu

Stigma initiatives / service user narratives

Media Action Group for Mental Health	www.magmh.org.uk
Time to Change	www.time-to-change.org.uk
Like Minds, Like Mine	www.likeminds.org.nz
See me	www.seemescotland.org
Narratives Research Project	www.scottishrecovery.net
Mental Health Stigma	www.mentalhealthstigma.com
Active Minds	www.activeminds.org
StigmaBusters	www.nami.org

Positive psychology resources

Centre for Applied Positive Psychology	www.cappeu.org
Positive Psychology Center	www.ppc.sas.upenn.edu
Centre for Confidence and Well-being	www.centreforconfidence.co.uk
Values in Action Inventory of Strengths	www.viastrengths.org

Appendix two: Reference list

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Mike Slade (report author)

The first edition has been translated into Danish, German, Portugese and Icelandic. Further information on these translations is available at researchintorecovery.com/100ways

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Rethink Mental Illness.

Leading the way to a better quality of life for everyone affected by severe mental illness.

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