

Becoming a recovery-oriented practitioner[†]

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ARTICLE

SUMMARY

Professional practice explicitly focused on supporting the recovery of those it serves is broadly backed by an emerging profile of necessary knowledge, key skills and innovative collaborations, although there is no universally accepted practice ‘model’. This article outlines these components and discusses the associated need for change in the culture of provider organisations along with implementation of wider social and economic policies to support peoples’ recovery and social inclusion. This is a values-led approach supported by persuasive advocacy and international endorsement but still in need of further development, systematic evaluation and confirmatory evidence.

DECLARATION OF INTEREST

Both authors work part time with the Centre for Mental Health in support of the national Implementing Recovery through Organisational Change (ImROC) programme.

‘The overall aim of mental health services is to help service users get back to living an ordinary life as far as possible.’ (National Institute for Health and Clinical Excellence 2002: para. 1.4.6)

‘The goal of recovery can be stated as enabling people to live full, satisfying and contributing lives.’ (Bradstreet for Scottish Recovery Network 2004)

The proposal that mental health workers should explicitly train to become ‘recovery-oriented practitioners’ has been gathering pace for over a decade (O’Hagan 2001; National Institute for Mental Health in England 2004a). It is now supported by professional endorsements (Care Services Improvement Partnership 2007), national policy (Department of Health 2011), advocacy from non-statutory organisations (Mind 2008; Rethink 2009), the views of lobbying alliances (Future Vision Coalition 2009), independent reviews (Rethink 2012) and the strategic commitments of a growing number of National Health Service (NHS) trusts.

In our first article (Roberts 2013) we described the growth of understanding and commitment to the principles of recovery in mental health services and will now look at how these might be

translated into practice. There is no overarching blueprint for recovery-oriented practice, but there is a developing consensus on the changes needed for mental health services and practitioners to be more supportive of people in their recovery.

A conceptual framework for recovery-oriented practice and services

The focus of recovery-oriented practice can be simply stated as seeking to enhance hope, control and opportunity (Shepherd 2010). Although this may offer some pointers as to what services may look like, it does not provide a sufficiently detailed framework for service design or training. The REFOCUS research group (Le Boutillier 2011) systematically reviewed 30 international documents aiming to address the question, ‘What does recovery mean in practice?’ Their thematic analysis grouped existing guidance on the key issues in recovery into four domains (Box 1). All are important when considering the development of comprehensive recovery-oriented service systems. Training and practice, which are the principal foci for this paper, are mostly covered by the first two domains which have a direct impact on the relationships and interactions between practitioners and the people they seek to serve. We will also briefly discuss the importance of organisational and societal contexts.

The role of practitioners in personal recovery

Practitioners cannot ‘recover’ people. Services can in many ways provide the preconditions of recovery through opportunities and supports but not recovery itself, as it needs to be discovered by the person themselves. Personal recovery is based on the individual becoming active and empowered in their own life, self-determining and self-managing. They may continue to use and benefit from a wide range of evidence-based treatments and services, but increasingly on their own terms.

A recovery-oriented practitioner is simply a practitioner who is able to effectively support people in their recovery. In reality, this is far from simple, as so much of what is important to people’s

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[†]In the previous issue of *Advances*, Roberts & Boardman discussed the ideas, principles and definitions of recovery (Boardman 2013). For a commentary on both articles, see pp. 48–51, this issue.

BOX 1 Key domains for recovery supporting practice**Working relationships**

Practitioners demonstrate a genuine desire to support individuals and their families to fulfil their potential and to shape their own future. A therapeutic relationship is essential in supporting recovery where partnership working and hope is promoted.

Supporting personally defined recovery

Practitioners focus on personally defined recovery and view recovery at the heart of practice and not as an additional task. Individuals are supported to define their own needs, goals, dreams and plans for the future to shape the content of care. Individuality, informed choice, peer support, strengths focus and a holistic approach are contained in this practice domain.

Organisational commitment

Organisations that support recovery demonstrate a commitment to ensure that the work environment and service structure is conducive to promoting recovery-oriented practice. The organisational culture gives primacy to recovery, and focuses on and adapts to the needs of people rather than those of services. Recovery vision, workplace support structures, quality improvement, care pathway and workforce planning sit within this practice domain.

Promoting citizenship

The core aim of services is to support people who live with mental illness to reintegrate into society and to live as equal citizens. Citizenship is central to supporting recovery, advocating the right to a meaningful life for people living with severe and enduring mental illness. Seeing beyond service user rights, social inclusion and meaningful occupation are grouped in this practice domain.

(Adapted from Le Boutillier 2011)

well-being may not be the main focus of mental health services (e.g. having a home (Wolfson 2006), personal relationships (Topor 2006), a job (Self 2012; Shepherd 2012)). But a focus on enabling people to live well necessarily engages with this broader view.

Extensive service user-led reviews define 'the basis for recovery oriented practice [as] the ability to build up respectful relationships with service users, in which the worker has a genuine interest in the person' (Schinkel 2007). This resonates with other findings which underline service users valuing engaged, humane and personal relationships that support hope and independence (Topor 2001; Borg 2004; Mind 2011). It is clear that how we work is as important as what we do.

Training for recovery-oriented practice

The principles of recovery have significant implications for the training of mental health practitioners, including doctors. Fundamentally, this is about changes in the culture of care and the quality of the working relationships between service users and practitioners, such that people are supported in regaining authority over their own lives and the role of professionals is to be 'on tap, not on top' (Repper 2003; Shepherd 2008). Many peer-led support groups have arisen from user activism greatly dissatisfied with standard

services, but taking a person-centred rather than profession-centred perspective means listening to and valuing the contributions of groups such as the Hearing Voices Network, National Self Harm Network and Paranoia Network and their offer of alternate knowledge (Knight 2009; Romme 2009).

Recovery-oriented training and service development will involve increasing partnerships with experience-based experts. The international literature broadly agrees on the key components of understanding recovery linked to an emerging portfolio of skills and competencies for all practitioners (Box 2). It also highlights specific issues in relation to medical responsibilities (Box 3). Taken together, this constitutes a provisional outline for training and development in recovery-oriented practice which forms the structure of the present article.

Understanding recovery as a foundation for practice

Training for recovery-oriented practice is based on having a good understanding of the origins and principles of personal recovery (Roberts 2013). Published and peer accounts of personal recovery illustrate the diversity of supports found useful by different people and offer the most direct route to bringing the principles alive.

Courses on recovery commonly invite learners to initially reflect on their own experience of loss, change and difficulty, and on what they found helpful from others. This experiential learning aims for an empathic resonance, emphasising that people with mental illness are fellow human beings who want and need much the same things in life as anyone else. It also provides an opportunity to explicitly value the 'lived experience' of practitioners.

There is often also a strong focus on the social determinants of distress and recovery (Tew 2012) as a foundation for culturally appropriate and trauma-informed care, and a humanistic orientation to engaging with who people are, where they have come from and what has happened to them.

Learners also need to be fully aware of the doubts and difficulties concerning the recovery concept (discussed in more detail in our first article, Roberts 2013). The key issue is not in advocating for 'recovery' so much as working for the values and outcomes associated with it. It is unhelpful to get bogged down in ideological dispute. Few, perhaps no, practitioners actually disagree with working to promote hope, enhance opportunity and restore control to people over their lives, even if they object to calling this recovery.

Creating a hospitable and welcoming environment

It is perhaps surprising that the first module of the American Psychiatric Association's draft curriculum on recovery-oriented practice focuses on 'engagement and creating a welcoming environment' (American Psychiatric Association 2012). In public services we often think that we just have to work with what is given, but this emphasises the importance of taking responsibility for cultivating a hospitable social and physical environment which literally sets the scene for trust, safety and engagement.

Supporting self-management

The Expert Patient (www.expertpatients.co.uk) and Co-Creating Health (www.health.org.uk/areas-of-work/programmes/co-creating-health/) programmes have demonstrated improved health outcomes for people with long-term physical conditions by supporting them in self-care (Health Foundation 2011). These increasingly popular approaches, particularly in primary care, are based on developing educational and supportive roles for experience-based experts as peer tutors and mentors working with health professionals who have modified their role towards being a 'guide' or 'navigator'.

Such supporters work in partnership with people to 'recognise and engage with their own resourcefulness and build on that rather than just offering treatment' (Collins 2012). Gradually, people are being encouraged to become increasingly self-determining of their care through the award of personal budgets (Alakeson 2012).

Psychiatry lags well behind physical medicine in supporting self-management. Internationally, the most popular approach (Slade 2009) is the Wellness Recovery Action Plan (WRAP; Copeland 2008) (Box 4), which provides a framework for personal planning based on discovering 'what works best for me'. Although routinely taught as part of 'support, time and recovery' (STR) worker roles in England, uptake has been patchy (Hill 2010a). Effective promotion has been more through independent service user groups (e.g. www.seftonrecoverygroup.org.uk) and a few NHS trusts linked to the Implementing Recovery through Organisational Change (ImROC) programme (Perkins 2007). Substantial training programmes in Ireland (Higgins 2010) and Scotland (Scottish Centre for Social Research 2010) have been favourably evaluated, demonstrating acceptability of WRAP and its capacity to support engagement with the core ethos of personal recovery, but long-term outcome evaluation is still needed.

BOX 2 Core components of a training course on recovery-oriented practice

Understanding for all practitioners (see Roberts 2013)

- 1 Understanding the origins and guiding principles of recovery
- 2 Personal reflections on recovery: what you have learnt from your own experience
- 3 Reflections on personal recovery: what we can learn from recovery narratives
- 4 Personal approaches to distress: culturally appropriate and trauma-informed care
- 5 The importance of language that enables and supports recovery
- 6 Concerns and challenges

Skills for all practitioners

- 7 Creating a hospitable and welcoming environment
- 8 Supporting self-management
- 9 Building on strengths and working to personal goals
- 10 Enabling self-direction and control: personalisation and personal budgets
- 11 Working with peer support
- 12 Recovery education for personal recovery
- 13 Bringing it all together: recovery-oriented care planning
- 14 Developing natural supports and promoting community participation

(O'Hagan 2001; Borg 2004; National Institute for Mental Health in England 2004a,b; NHS Education for Scotland 2007, 2008; Davidson 2008; Shepherd 2010; Bird 2011; Victorian Government Department of Health 2011; American Psychiatric Association 2012; Centre for Mental Health 2012)

Building on strengths and working towards personal goals

Recovery-oriented practice emphasises the importance of shifting from primarily a clinical focus on people's symptoms and disabilities towards recognising and building on peoples' strengths and positive attributes (McCormack 2007). A focus on strengths draws on established

BOX 3 Issues relating to medical responsibilities in recovery-oriented practice

- 1 Engaging with knowledge and skills for all recovery-oriented practitioners

Additional understanding

- 2 Recovery and realism: open to all?

Additional skills

- 3 Promoting recovery for people detained under the Mental Health Act 1983
- 4 Reconsidering risk and safety
- 5 Medication management and supported decision-making
- 6 Practitioners in context: participating in organisational change
- 7 Practitioners in context: participating in societal and cultural change
- 8 Tracking progress: evaluation and outcome measures
- 9 Continuing professional development: supports and resources

(Sources: as for Box 2)

BOX 4 Sources and resources to support training in recovery-oriented practice

UK

Implementing Recovery through Organisational Change (ImROC) (www.imroc.org): the English national supporting recovery programme hosted by the Centre for Mental Health and the NHS Confederation

Research into Recovery (www.researchintorecovery.com): home for the Institute of Psychiatry's Section for Recovery, including the Refocus Programme and National Recovery Research Network

Rethink (www.rethink.org/living-with-mental-illness/recovery/what-is-recovery): the largest national voluntary sector provider of mental health service and support groups in England explicitly committed to recovery-oriented approaches

Recovery Devon (www.recoverydevon.co.uk): a long-established local 'community of goodwill' that includes a resource library of leading papers, policies and other background materials

The Scottish Recovery Network (www.scottishrecovery.net): government-funded lead to develop a healthier Scotland through implementing recovery

Working to Recovery (www.workingtotherecovery.co.uk): resource website from Ron Coleman, one of the user-founders of the recovery movement in the UK

International

Boston Centre for Psychiatric Rehabilitation (<http://cpr.bu.edu>): repository of recovery resources

Mental Health Recovery (www.mentalhealthrecovery.com): Mary Ellen Copeland's website based on the Wellness Recovery Action Plan

Recovery Opportunity Center (www.recoveryopportunity.com): the training and consulting wing of Recovery Innovations, an internationally recognised network of recovery-oriented mental health services based in Phoenix, Arizona, USA, and the source of training and guidance on peer support and recovery education for service users

Substance Abuse and Mental Health Services Administration (SAMHSA)/Yale 'Recovery into Practice' initiative (www.samhsa.gov/recoverytopractice/ and www.samhsa.gov/recovery/): a 5-year federally funded programme led by SAMHSA and the Centre for Mental Health Services, with an aim to translate the vision of recovery into the concrete and everyday practice of mental health professionals of all disciplines

experience in occupational therapy and rehabilitation psychiatry (Rapp 2006), and there is a growing interest in mental health practitioners developing coaching skills (Bora 2010, 2012; Bird 2011) to support people in using their abilities to achieve personal goals.

Working with peer support

Psychiatrists are mandated to meet regularly with peers for professional support, supervision and mentoring, but few are familiar with the emerging role of peer support workers in NHS teams and services. Many stories of personal recovery pivot around meeting someone who believes you, validates your experience and expresses confidence in your future. Frequently, this 'hope-inspiring relationship' (Repper 2003) is with a peer, someone who has experience-based expertise and can offer companionship as a fellow traveller,

upholding the possibility of recovery through embodying it themselves.

Peer support occurs naturally and is the backbone of many non-statutory or volunteer-based services and this has led to training and support for more structured peer support worker roles. Systematic reviews of the large number of descriptive and qualitative studies and rather fewer randomised controlled trials (Woodhouse 2006; McLean 2009; Repper 2011; Faulkner 2012) have reported a range of benefits associated with employing peer workers. These include reducing readmissions, enhanced community integration, increasing confidence, self-esteem, empowerment, practical help and guidance, and challenging stigma and discrimination, benefits which appear to also apply to the peer workers themselves (Repper 2011, 2012).

There is sufficient evidence for early adopters in the UK to have offered guidance on best practice and associated challenges (Scottish Recovery Network 2011; Pollitt 2012; Repper 2013a), but more extensive trials are needed to clarify outcomes.

Recovery education for personal recovery

Despite William Oswald's dictum of 100 years ago that 'the best teaching is that taught by the patient himself' (Spencer 2000), it has been remarkably easy for psychiatric teaching and training to drift away from meaningful engagement with personal perspectives and stories (Roberts 2000). Where patients are involved in medical education there has been a trend for them to be a passive presence, 'acting as interesting teaching "material", often no more than a medium through which the teacher teaches' (Spencer 2000).

The National Institute for Health and Care Excellence (NICE) guidance (National Institute for Health and Clinical Excellence 2011) strongly advocates for a cultural shift to ensure that the experience of patients shapes services. The advent of Recovery Education Colleges in NHS trusts (Perkins 2012) is based on a philosophical shift from 'treating' to 'learning and enabling' and a practical shift towards creating learning opportunities that are characteristically co-designed, co-produced and co-delivered by people with personal and professional experience of working together. Particular value is given to people who have both professional training and personal experience (Dorset Wellbeing and Recovery Partnership 2012) and are thus 'dual qualified'. Developing curricula include many of the suggestions in this and our previous article (Roberts 2013) and an opportunity for staff and

patients to learn together, turning experience into expertise.

Bringing it all together: recovery-oriented care planning

The care programme approach (CPA) was always intended and designed to be a means of drawing together all the contributors to someone's care and treatment, built around a comprehensive assessment of need and with full involvement of the person themselves, who confirmed this co-produced 'contract for care' by signing it off themselves (Holloway 2006).

Done well, CPA can certainly be a successful vehicle for recovery-oriented care planning. However, recurrent reviews have found low levels of co-production and that 'service users expressed concern at the lack of attention to their wider social care needs [...] particularly when the focus has been on problems and risk [...] rather than building strengths towards recovery' (Department of Health 2006: p. 2). This led to proposals for refocusing CPA (Department of Health 2008a) so as to promote safety, positive risk-taking and recovery. However, this practitioner-led framework continues to fall short of offering a reliable and user-friendly support for people's own recovery planning (Gould 2013).

There is need for improvement. Some organisations have developed structured supports for personal recovery planning based on WRAP, and others are modelling their electronic records system to prompt more person-centred care. But how to reconcile a truly person-centred framework with institutional and organisational needs for documentation remains an elusive goal at present.

Developing natural supports and promoting community participation

People live in society, not mental health services, but it is not uncommon for people with severe mental health problems to have lives centred on contact with fellow patients, staff and mental health facilities. An emphasis on personal recovery includes recovery of personal networks of social contacts and supports, family and friends (Repper 2013b) and opportunities for participation that characterise ordinary people's lives (College of Occupational Therapists 2006). Recovery-oriented practice cannot provide these resources, but they can support people discovering or reconnecting with them and also work with public health and emerging civic structures (e.g. health and well-being boards), whose responsibilities include developing community resources and opportunities available to local people (Boardman 2012).

Is recovery really 'open to all'?

Some practitioners have been concerned that the very challenging realities of living with severe, long-term and complex mental health problems, neurodevelopmental conditions, and progressive organic psychiatric illness are such that it is unhelpful, unrealistic and possibly unkind to speak of recovery. That, in these severe, structural or progressive conditions the recovery approach has met its limits and it is illusory and wishful to consider it 'open to all'.

However, this concern may be based on a misunderstanding of recovery which equates it with 'cure'. The overlaps between the philosophies of recovery, person-centred care and valuing people have led to growing contributions from practitioners working with incapacitous adults (see below), older adults and in dementia care (Hill 2010b; Cheffey 2013; Daley 2013), severe intellectual disability (Roberts 2007; Esan 2012), and with friends and supporters (Fadden 2012). The call for 'recovery to become a better understood and accepted approach across all mental health specialties' (Royal College of Psychiatrists 2008a) is supported by policy (Department of Health 2011) and affirmed in a cross-specialty position statement asserting that 'recovery is for all' (South London and Maudsley NHS Foundation Trust 2010). Even in circumstances that end in tragedy or death, those who survive will need to find ways to consolidate their grief and loss with recovering their lives. Many of the guiding values and principles of recovery are also those on which the hospice movement was founded. Upholding the values is the key issue and the language will need to be modified according to context.

Promoting recovery for people detained under the Mental Health Act 1983

The Royal College of Psychiatrists' joint position statement asserted that there should be 'no recovery-free zones' in our services with an associated need to 'work out the implications of recovery thinking in the most difficult of circumstances, where choice and responsibility may be most compromised' (Care Services Improvement Partnership 2007: p. 26). This is fully supported by the Mental Health Act 1983 *Code of Practice* (Department of Health 2008b: p. 5), which describes 'promoting recovery' as one of the four guiding purposes for using the Act and is reasserted in successive reviews by regulators (Mental Health Act Commission 2007: p. 9; Care Quality Commission 2011).

The issue is therefore not one of principle so much as practice. This has led to an exploration of how

to use choice as a support for recovery for people who are detained (Roberts 2008); a discussion concerning the challenge to recovery approaches from working with offender patients and *vice versa* (Dorkins 2011; Roberts 2011); and a broader view promoting the applicability of recovery principles in secure and prison-based services (Drennan 2012). There is growing confidence that the Mental Health Act can be both a means and a context for personal recovery but there is much to learn in how to make that a reality (Shepherd 2014).

Coercion is a particular concern. Compulsion and coercion are often taken to be synonymous but the word coercion does not appear in either the Mental Health Act or the *Code of Practice*. At times of incapacity, unacceptable risk and excessive suffering there may be a legally mandated need for involuntary or compulsory measures, but this does not need to be conducted through coercive measures with overtones of force, intimidation, threat, punitive restrictions or punishments.

The importance of this distinction is confirmed in the final report of the Mental Health Act Commission (2009), which states:

‘Defensive and therefore coercive practice is not, in our view, an inevitable approach towards patients who are detained under the Act’ (para. 1.93),

and in recommending adoption of recovery-oriented care for detained patients, it says:

‘Values such as respect, choice, patient involvement and autonomy should be seen as integral to all aspects of psychiatric care, rather than being only a counterbalance to its more coercive aspects’ (para. 1.93).

Coercive practice is bad practice.

Reconsidering risk and safety

Concern for risk and accountability for safety is close to the core responsibilities of psychiatrists and modifications in risk management may be central to developing recovery-oriented practice. Trainees quickly learn to ‘do a risk assessment’ and offer suggestions for risk management. They may be less aware that there is long-standing concern over inappropriately restrictive risk-averse practice (Royal College of Psychiatrists 2008a), which has been seen as ‘undermining meaningful clinical decision making and making engagement with patients more difficult’ (Morgan 2007). This contrasts with the largely unimplemented Department of Health best practice guide on risk management (Department of Health 2007a), which recommends positive risk management in a spirit of collaboration, recognising the service user’s strengths and emphasising recovery. This

is reaffirmed in substantial reviews by the Royal College of Psychiatrists on risk of harm to self (Royal College of Psychiatrists 2010) and others (Royal College of Psychiatrists 2008b), whose recommendations form the basis of a forthcoming NHS Confederation briefing paper reframing risk management as ‘person-centred safety planning’ (Boardman 2014).

Medication management and supported decision-making

The Schizophrenia Commission concluded that although medication was, for many, a foundation on which personal recovery was built, ‘current practice is inadequate’ (Rethink 2012: p. 29). They cited the unacceptable and dangerous side-effects of some medications coupled with lack of negotiation and support for choice and preference in decision-making, leading to an ill-informed or adverse service user experience. Their recommendation that ‘shared decision making’ must form the cornerstone of practice and that ‘the training of psychiatrists in personalised prescribing practice is crucial’ (Rethink 2012: p. 31) is entirely consistent with established, but poorly implemented, Department of Health (2007b) guidance on best practice and even the basic duties of a doctor, which highlight partnership working and respect for ‘patients’ rights to reach decisions with you about their treatment and care’ (General Medical Council 2013).

International recovery leads (Deegan 2006) have conceptualised medication as one of many possible tools that a person can actively use to support their well-being for a limited period (Baker 2013). Even when working with people with impaired capacity and needing compulsory treatment it remains possible to uphold kindness, respect and some aspects of choice and preference (Baker 2013). There appears to be considerable room for improvement in current practice and the teasing possibility of significant therapeutic enhancement from treatment which is negotiated in a person-centred way (Mulley 2012).

Practitioners in context: participating in organisational change

Being a psychiatrist is more than just a job. It is a privileged role based on trust and respect, an education and an identity. It is common for medical practitioners to personally identify with their occupational role and derive existential satisfaction from their work. However, in the UK we are also almost universally employees working in publicly funded teams and services. Psychiatrists are often

the most senior practitioners in their teams, with leadership responsibilities, but a great deal of what we are able to do in our work is enabled or constrained by the expectations and demands on us and the resources we are given to work with.

It follows that the ability to deliver recovery-oriented services and outcomes will depend not only on training practitioners, but also on how effectively they are supported and managed by their employing organisations. In England, the Department of Health has sponsored a national programme, ImROC (www.imroc.org), to 'test the key features of organisational practice to support the recovery of those using mental health services' (Department of Health 2011: p. 22, para. 3.20). This is structured around responding to ten key challenges identified as developmental milestones for any recovery-oriented service (Shepherd 2008, 2010; Centre for Mental Health 2012a). The programme emphasises the need for cultural change rather than reorganisation and to ensure the values of recovery are implemented at every level. It also concurs with earlier advice (Whitley 2009) that effective training needs to be supported by changes in supervision, leadership and a culture of innovation.

Practitioners in context: participating in social and cultural change

Psychiatry has seldom had good press and there are active and ongoing efforts to improve the public image and public perception of both mental health problems and psychiatric services. Stigma and discrimination are regarded as equally or more important to the life experience of people with mental illness as the illness itself, and working to improve societal attitudes is vigorously represented in current outward-looking mental health policy (Department of Health 2011), the gathering momentum for public health education and in anti-stigma campaigns such as Time to Change (www.time-to-change.org.uk).

The Royal College of Psychiatrists is supportive of psychiatrists working to improve services and to fulfil important leadership roles in their teams and organisations. The civil rights roots of recovery suggest still wider roles and relationships and that recovery-oriented professionals of the future should also lend their skill, authority and influence to social activism and support for social justice (Slade 2010). This is about working not only in the community but also with the community, seeking to influence issues pivotal to people's lives such as income, housing and employment (Boardman 2012).

Tracking progress: getting the measure of recovery

Measuring personal recovery outcomes in routine practice will be important for the evaluation of services and practices (Thornicroft 2010), but it is not easy. The current Mental Health Implementation Framework observes that 'there are key aspects of mental health, such as recovery, for which agreed outcome measures are not yet available' (Centre for Mental Health 2012b: p. 15).

There have been many candidate measures (Ralph 2000; Campbell-Orde 2005; Burgess 2011; Williams 2012) but there is continuing uncertainty regarding which to use (Williams 2012) and few have been designed for use in a UK context (Donnelly 2011). Personal recovery outcomes may be regarded as distinct from the traditional 'clinical outcomes' of changes in symptoms and functioning, but they overlap with them. No single measure can satisfactorily capture all the salient dimensions, i.e. a subjective self-evaluation of 'my progress in my recovery' or quality of life, with a user-evaluated assessment of their experience of 'how well you are supporting me in my recovery', in the context of more observable indicators of 'how well I'm getting on with a life beyond illness', including attainment of individual goals and social roles, employment, housing, education, training and social networks. Improved measures and guidance are expected from research and policy in the near future (Box 4).

What is the jobbing psychiatrist to do: CPD for recovery-oriented practice?

This and our previous article (Roberts 2013) have been written in line with national policy, international trends and the ambition to improve quality and outcomes. But practising clinicians face a perennial challenge in knowing how best to respond to the steady flow of ideas and suggestions for change. Many feel underresourced and over-managed and are cautious about additional tasks. Some are understandably concerned that the enthusiastic promotion of recovery approaches is not yet supported by robust outcome evaluation. However, the present emphasis on developing recovery-oriented practice is not so much about an additional or supplementary agenda as about getting the basics right. It is about refocusing the conceptual compass guiding all practice and service development so as to be fundamentally oriented on enabling outcomes valued by the people we seek to serve.

A core commitment to recovery aims to be practical, hopeful and helpful. It is of little value

BOX 5 Practical steps in developing as a recovery-oriented practitioner

- 1 Deepen your understanding of personal recovery through stories of personal experience
- 2 Give time to reading and learning about recovery-oriented practice
- 3 Find colleagues with shared interests, within existing peer groups or elsewhere
- 4 Take stock of how your current practice compares with what is described as recovery-oriented practice
- 5 Use measures and tools that support self-reflection on recovery-oriented practice
- 6 Conduct local audits of recovery knowledge or practice and use results for action planning
- 7 Take small steps of change: devise local development projects with service users that are within your scope to complete
- 8 Network: gain support from others involved with developing recovery-oriented practice, locally or nationally
- 9 Look for meetings and training opportunities, to learn from and share experience of recovery innovations
- 10 Work with others to designed and delivered recovery education

if it is not. It is about enabling people to live well, and what is good for our patients may be good for us also (Care Services Improvement Partnership 2007: p. 26).

We may also wonder where to start and, at the risk of being simplistic, some practical steps,

available to anyone, can be suggested (Box 5). These centre on finding supportive peers and learning with and from people with personal experience. Practitioners may also find it helpful to use guides such as the Centre for Mental Health's 'Ten Top Tips' (Box 6) in support of self-reflection and self-supervision, and consider learning about self-management support tools such as WRAP by using them personally.

We can only start from where we are, and as we compare our current practice with these ideas and aspirations we may well find that in some measure we are 'doing it already' and that there is something to celebrate. We may also find it interesting and helpful to take a look at the many supportive resources offered by the international network of recovery innovators with our peers and teams (Box 4).

Can we afford to innovate in a time of austerity?

Service design and development is set to be dominated by financial considerations. Cost improvements and cuts are already being made across public services and the welfare state, accompanied by a demand for quality improvement. Reducing existing services is not a viable route to improvement, so there is a need for creative, intelligent and constructive change if there is any hope of reconciling these apparently contradictory ambitions (Royal College of Psychiatrists 2009).

The possibility that recovery-oriented services could be both more effective and less costly enabled a leading trust CEO to propose that: 'When it is done properly [recovery] can have a significant and beneficial impact on the performance of the organisation in business terms. Instead of being a slave to compliance and regulation, you will find that getting recovery right means that you'll invariably be ticking all the boxes around quality, safety, efficiency and involvement' (Cooke 2012).

It makes sense that if people are enabled to look after themselves more successfully, develop community-based resources they value and construct lives they want to live, they are correspondingly likely to have reduced needs for services and be better placed to contribute to the economy (Rinaldi 2012). There is therefore an unevaluated but realistic possibility that recovery-oriented services may not only be better in terms of the quality of user experience and outcomes, but also less costly (Mulley 2012). This is consistent with Lord Kestenbaum's (2010) view that recovery innovations in mental health services 'could be crucial to their renewal'. A possibility that we cannot afford to ignore.

BOX 6 Self-evaluation using the Ten Top Tips for recovery-oriented practice

After each session ask yourself, did I...?

- 1 help the person identify and prioritise their personal goals for recovery (not the professional's goals)
- 2 show your belief in the person's existing strengths in relation to the pursuit of these goals
- 3 identify examples from my own lived experience or that of other service users, which inspires and validates hope
- 4 accept that the future is uncertain and that setbacks will occur, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations
- 5 encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)
- 6 listen to what the person wants in terms of therapeutic interventions (e.g. psychosocial treatments, alternative therapies, joint crisis planning) and show that I have listened
- 7 behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together
- 8 indicate a willingness to 'go the extra mile' to help the person achieve their goals
- 9 pay particular attention to the importance of goals that take the person out of the traditional sick role and enable them to serve and help others
- 10 identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of these goals

(Shepherd 2008)

Conclusions

The concept of recovery-oriented practice has moved on from ideological debate and abstract principles to a commitment for working it out in practice.

The recent independent review of the care and treatment of people with severe mental illness (Rethink 2012: p. 44) recommended that all mental health providers invest in 'recovery-focused whole-system transformation and development for staff, such as the ImROC programme and that professional and educational bodies review their curricula to support such transformations.' There is an emerging international consensus on what such changes in professional curricula could look like (Boxes 2 and 3), accompanied by a considerable need for evaluation and outcome studies to focus innovation. Although explicit training for recovery-oriented practice is at an early stage, it clearly involves extending our knowledge, broadening our skills and participating in cultural change.

Learning opportunities are currently framed as additional and optional modules. However, if the advocacy for recovery to be the common purpose of all mental healthcare is taken seriously, these principles could be woven into core curricula and systematically supported in practice through training, supervision, continuing professional development, appraisal and awards.

It is then an ambitious, but not unrealistic, possibility that in another decade we will have moved on from talking about the training implications of recovery-oriented practice to having incorporated these principles into a values-led, person-centred redefinition of good practice that is more able to effectively support people in their recovery and enable them to get on with their lives, on their own terms. The real test will be whether those receiving our services agree.

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MCQ answers

1 d 2 d 3 c 4 d 5 c

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MCQs

Select the single best option for each question stem

1 Core components of training for recovery-oriented practice include:

- a developing skills for cognitive-behavioural therapy for psychosis
- b intensive training in neuroimaging
- c experience of mental ill health
- d learning from the personal accounts of people with lived experience of mental health problems
- e working in crisis resolution and home treatment teams.

2 Key challenges for developing recovery-oriented services in NHS mental health trusts include:

- a improving the on-call rotas for trainees
- b the provision of mix-gender acute wards

- c implementing better hygiene standards
- d developing training for peer support workers
- e increasing psychiatric liaison services with general hospitals.

3 Peer support workers:

- a can be found working in community mental health teams in most NHS mental health trusts
- b can help to increase the amount of time spent in hospital
- c can help increase confidence and self-esteem in other service users
- d reduce the hope of recovery in others
- e are only used in substance misuse services.

4 Good recovery-oriented practice includes:

- a clearly identifying a person's main weaknesses
- b prioritising a patient's goals for them
- c discouraging a person to manage their own problems

- d promoting a strengths-based approach
- e encouraging social isolation.

5 Recovery-oriented services:

- a are only of use for people with schizophrenia
- b prioritise the delivery of alternative therapies
- c require the commitment of NHS mental health trusts and their CEOs
- d give low priority to education and training
- e aim to discharge people after 6 months.