Elements of recovery: International learning and the Scottish context

SRN Discussion Paper Series: Paper 1

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About Scottish Recovery Network discussion papers

This is one of a series of discussion papers designed to help generate debate on how best to promote and support recovery from long-term mental health problems in Scotland. A number of source materials were used to inform its development and it is hoped that over time it will be developed and adapted in the light of learning and comments from people around Scotland who have an interest in promoting and supporting recovery from long-term mental health problems.

Contact the Scottish Recovery Network for more details on the series.

About the author

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Summary

International learning indicates that a number of key elements help to promote and support recovery from long-term mental health problems. These include creating the conditions which foster hope and belief that change is possible and which give purpose and meaning to people's lives. Also important are the opportunities available for someone with long-term mental health problems to participate actively in choices and decisions about their life.

Experience in other countries indicates that recovery is influenced by many different factors:

- The attitudes and expectations people hold about mental health and mental health problems.
- The support provided by helping services.
- The opportunities and obstacles people with long-term mental health problems meet in seeking to enjoy satisfying lives.

People who experience long-term mental health problems are amongst the most socially excluded in society experiencing, for example, high levels of unemployment and social isolation (Social Exclusion Unit Report, 2004.). However, this is a time of opportunity with a very positive policy environment and considerable levels of enthusiasm and interest in how best to promote and support recovery.

The Scottish Recovery Network exists to generate debate around recovery and to share learning. This paper aims to act as an introduction to that debate. It poses questions and challenges for us to consider collectively in Scotland about how best we can create the conditions that support recovery.

Introduction

This paper is based on international learning around what people have identified as important elements in the promotion and support of recovery from long-term mental health problems. It is by no means exhaustive and should be seen as an illustrative guide to understanding recovery, designed to generate debate and discussion, rather than a definitive statement on what is unquestionably a highly individual and specific experience.

It will examine issues around the interpretation of recovery and consider elements which have been identified elsewhere as important to recovery and go on to consider why it is necessary to promote recovery and consider the wider policy context into which it fits.

The extent to which someone can recover a fulfilling, satisfying and meaningful life, whether or not they continue to experience symptoms, is affected by a wide range of factors, some of which are related to mental health services but certainly not all. Some may be related, for example, to the public's understanding of mental health issues, while others may be influenced by access to educational opportunities or the presence or absence of supporting social networks. The Scottish Recovery Network aims to work across all communities when considering how best to promote and support recovery.

What's in a word?

Increasingly people involved in mental health policy and service development are making reference to recovery. While this is clearly a positive development it is less clear whether or not there is a consensus on what it actually means and how best to help individuals towards recovery.

In the United States where recovery has been most extensively developed and adapted as a 'model' for service development, endorsed in both the Surgeon General's Report on Mental Illness (Sacher, 1999.) and the report of the New Freedom Commission on Mental Health (2003), there remains confusion as to how best to interpret and promote recovery. A recent paper argues that this confusion can be ascribed to different understandings of what the word recovery means. (Davidson *et al*, 2005)

More traditionally recovery is understood to mean getting back to the way you were before or back to *normal.* While we know that people can and do recover, in this traditional sense, from long-term mental health problems (1), recovery as it has been promoted internationally over the last twenty or so years, primarily by the service user movement, describes a broader more holistic interpretation of the word, well summarised by Anthony (1993):

> *[Recovery] is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development*

of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

So recovery in this sense provides an empowering message of hope, which says that regardless of symptoms people with serious mental health problems should be given every opportunity to lead a fulfilling and satisfying life. It looks at life first and symptoms second and proposes that the opportunities available to members of a community should not be determined by their mental health. It is about much more than the absence of symptoms.

Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them. (Curtis, 1997.).

Recovery by its very nature is complicated and while there may be common themes and experiences no two people's recovery journeys will be identical by virtue of the fact that we all have very different interests, needs, dreams, motivations and desires. Our background, culture, gender and past experiences also impact considerably on our experience of recovery.

It is unlikely that recovery will be a linear process. Serious mental health problems are generally episodic and recurring and people will, of course, experience set backs in their recovery journey. This does not in any way signify failure or suggest that things must go back to square one.

One way to better understand recovery is to consider the elements, which it is generally agreed, must be present in order to promote and support recovery.

Elements of recovery

There have been numerous attempts to define the key elements of recovery (for example; Repper & Perkins, 2003., Curtis, 1997., Anthony, 1993.). The following list, while not exhaustive, summarises the most commonly agreed key components.

Without *hope* recovery is not possible. There can be no change without the belief that a better life is both possible and attainable.

The emotional essence of recovery is hope, a promise that things can and do change, that today is not the way it will always be. (Jacobson & Curtis, 2000.).

Another key theme is the discovery (or rediscovery) of *meaning* and *purpose* in one's life. Different people find meaning in very different ways, for example, some people may find spirituality important while others may find meaning through the development of stronger interpersonal or community links.

In tandem with this a recovery approach necessitates a fundamental belief that everyone has the potential for *change*. It challenges the traditionally pessimistic outlook of mental health professionals influenced by a historical belief in the chronic nature of some mental health problems. It also proposes that episodes of illness, while clearly distressing, can in fact be developmental and educative experiences.

Control is central to recovery. People who use mental health services are sometimes denied an adequate level of involvement in their own care and treatment.

> *At its simplest recovery can be defined as a subjective experience of having regained control over one's life.* (Allott & Loganathan, 2002.).

Whilst it is recognised that some people may at times be less able or willing to participate in planning we should be aiming to move from a situation where people using services are sometimes passive recipients to one where they are *active participants*.

> *In contrast to the passivity of being a patient or a voiceless recipient of services, recovery is active and requires that an individual take personal responsibility for his or her own recovery, often in collaboration with friends, family, supporters, and professionals.* (Jacobson & Curtis, 2000.).

To promote control *self-management* techniques and mental health literacy should be developed amongst service providers and users.

Similarly service users should be seen as '*experts by experience*' and be involved in the development of recovery focussed services and policies.

Recovery is a *holistic* and *inclusive* approach that considers all elements of a person's quality of life. It recognises that the extent to which someone enjoys good health and well-being is influenced by a very wide range of social, environmental and individual factors and is about much more than the management of symptoms.

The extent to which recovery is possible is greatly influenced by a person's *environment*. The extent to which someone can recover is affected by external factors like stigma and discrimination, employment and training opportunities, housing and social exclusion.

At the same time as being *optimistic* a recovery approach should be *realistic* – recovery is rarely a linear process – people will have periods where their recovery is slowed by a bout of illness.

Services are rightly concerned about managing risk but the danger is that it becomes the overriding concern. For someone to overcome a disabling illness and become actively involved in their community requires an element of *creative risk taking*.

What recovery is not

Through starting to identify key elements we can also start to address some misperceptions around attempts to promote recovery.

Recovery is not about setting a gold standard – it is not about testing people to assess the extent to which they have recovered and penalising them if they have failed. As we have seen everyone's recovery is different. Some people may not be ready, or may be unwilling, to take a more active role in managing and controlling their health. Anyone involved in offering support to someone with a mental health problem should be flexible enough to deal with this but work from the point of view that where possible recovery should be facilitated.

It should not be seen as a means or justification for moving people through services more quickly. For many people being able to access services and supports when and where they need them can be a vital aspect of the recovery process.

While promoting inclusion is essential to people's prospects of recovery from long-term mental health problems, social inclusion and recovery are not one and the same thing.

Recovery should not be seen as an add-on to mental health services or policy. It should be promoted and supported throughout mental health systems from initial diagnosis onwards. It is in this crucial aspect that it differs from traditional models of rehabilitation - services that tend to be accessed when someone has been involved in using mental health services for some time – there should be no 'qualification period' for recovery focussed services.

> *Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability. (*Deegan, 1988.).

Why promote recovery?

People who experience long-term mental health problems are amongst the most excluded in society and, to a large extent, have not enjoyed the benefits of the disability rights movement. (Sayce, 2000.).

> *Only 24 per cent of adults with long-term mental health problems are in work – the lowest employment rate for any of the main groups of disabled people.* (Office for National Statistics, (2003.).

While we recognise that effectively promoting and supporting recovery is an issue for all sectors of society a number of papers have looked at outcomes commonly associated with what have been described as 'recovery-focussed' mental health services. One paper notes the following factors:

- *Reduced hospitalisation re-admissions, lengths of stay and other measures of hospital utilization;*
- *Positive gains in employment status;*
- *Skill development in cognitive, emotional, social, and physical skills;*
- *Client satisfaction;*
- *Stability in accommodations;*
- *Improvements in perceptions of quality of life.* (Curtis 1997)

The extent to which recovery is promoted amongst services is poorly researched but anecdotally some service users report limited aspirations amongst people providing services and the wider community.

> *The forgotten generation place few demands on the state. Their contact with health and social services is mainly restricted to collecting their "meds."* (Rethink, 2004.).

Where services work towards a recovery orientation and recovery is actively promoted more widely the international experience tends to suggests that people with long term or recurring mental health problems are enabled to take up work opportunities and to lead meaningful and valued lives within their communities.

The policy context

As well as being one of the four key aims of the National Programme for Improving Mental Health and Well-being (National Programme, 2003.), promoting and supporting recovery is consistent with the twin pillars of current health and social policy: health improvement and social justice. The goals of recovery - to enable people to live full, satisfying and contributing lives – are echoed in the Scottish Executive's Social Justice milestones and in the aspirations to tackle inequalities within and between communities in Scotland.

Government health policy in general is becoming increasingly 'user focussed' with the individual receiving care being moved to the centre of all therapeutic relationships. This is in tandem with an increasing demand amongst health service users to be at the core of the decision making process, as outlined in Partnership for Care (Scotland's Health; White Paper, 2003.). The recovery agenda is entirely consistent with this policy context.

The Framework for Mental Health Services in Scotland (Framework, 1997.) has led to developments in community mental health services, which provide support and treatment to enable people with long-term mental health problems to live ordinary lives in their own families and communities. More recent developments in mental health policy, elaborated in Moving the Agenda Forward (2), give increasing emphasis to the importance of self-help and mutual support. Recovery provides an additional impetus to this by focusing on individual choices and goals and the skills and supports required from helping agencies to achieve them.

Similarly the principles that shaped the formulation of the Mental Health Care & Treatment Act 2003 (HMSO, 2003.) give emphasis to the user voice in making choices and decisions. Specific changes that could help promote recovery include the introduction of advance statements, care plans, improved access to advocacy and new Local Authority duties. Sections 25 to 27 outline how local authorities must work to ensure people with mental health problems are afforded opportunities to promote well-being and recovery. Section 26 for example states that Local Authorities should promote well-being and social development including social, cultural, recreational, training and employment opportunities.

As we move towards full implementation of the Act it will be important to ensure that these aspirations become a reality in the ways in which practitioners, service users and families engage with the new measures under the Act.

Conclusions

International evidence helps us better understand some of the elements that have been shown to be important in promoting and supporting recovery from long-term mental health problems. No two people's recovery experience will be the same.
The Scottish Recovery Network hopes to learn more about what helps keep people well and what supports recovery as we work to encourage and build a Scottish evidence base around recovery.

We do know that many different things enable people to keep well and to recover. It will therefore be important that work in Scotland to promote recovery spans different communities, to include the general public and local communities, public services including mental health services but also mainstream services such as education, housing and employment.

We are fortunate in Scotland in having a policy environment which is overwhelmingly positive in its support for recovery but there is a clear need to complement and build on existing efforts to promote recovery. The Scottish Recovery Network aims to contribute to this by providing opportunities to share ideas and experiences and to generate a stronger understanding of the principles, attitudes and practices that underpin recovery. We hope you will be able to take part and contribute your experience to this.

Commenting and finding out more

If you have any comments to make on this discussion paper, would like to contribute to the work of the Scottish Recovery Network or would like to join the mailing list then please email info@scottishrecovery.net. Alternatively phone 0141 240 7790 for more details.

References and further reading

1. Long term research studies suggest that up to two thirds of people will recover from long-term mental health problems. Most studies have concentrated on schizophrenia and indications of recovery can vary between studies. See for example;   Davidson, L., & McGlashan, T. H. 1997. The varied outcomes of schizophrenia. *Canadian Journal of Psychiatry*, 42: 34-43.

2. A series of events and papers hosted and developed by the Scottish Executive in 2003.

Allott, P., & Loganathan, L. 2002. Discovering hope for recovery from a British perspective: A review of a sample of recovery literature, implications for practice and systems change.

Anthony, W. A. 1993. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychiatric Rehabilitation Journal*, 16(4): 11-23.

Curtis, L. 1997. New Directions: International Overview of Best Practices in Recovery and Rehabilitation Services for People with Serious Mental Illness, *A Discussion Paper*. NZ: The Commission to inform the development of a National Blueprint for Mental Health Services. http://www.mhc.govt.nz/publications/1997/New_Directions.htm

Davidson, L., O'Connell, M. J., Tondora, J., Staeheli, M., & Evans, A. C. (2005) Recovery in serious mental illness: Paradigm shift or shibboleth? Professional Psychology: Research and Practice, 36.

Deegan, P. E. 1988. Recovery: The lived experience of rehabilitation. *Psychiatric Rehabilitation Journal*, 11: 11-19.

Framework for Mental Health Services in Scotland. 1997. Scottish Executive Health Department. *NHS Scotland.*

HMSO, (2003). *Mental Health (Care and Treatment) (Scotland) Act 2003*

Jacobson, N., & Curtis, L. 2000. Recovery as policy in mental health services: strategies emerging from the States. *Psychiatric Rehabilitation Journal*, 23(4): 333-341.

National Programme for Improving Mental Health and Well-Being action plan 2003-2006: The Scottish Executive; Health Department. September 2003.

New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

New Zealand Mental Health Commission, (1998), *Blueprint for Mental Health Service in New Zealand.*

Office for National Statistics, (2003). Labour Force Survey (figures for England only) sited in Office of the Deputy Prime Minister, (2004). *Mental Health and Social Exclusion: Social Exclusion Unit Report*

Office of the Deputy Prime Minister, (2004). *Mental Health and Social Exclusion: Social Exclusion Unit Report*

Partnership for Care; Scotland's Health White Paper: The Scottish Executive; Health Department. February 2003

Repper, J., & Perkins, R. 2003. ***Social inclusion and recovery: a model for mental health practice***. Edinburgh: Baillière Tindall.

Rethink. 2004. Lost and Found: Voices from the Forgotten Generation: Rethink Publications.

Sacher, David. (1999) *Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services. Rockville, MD. http://www.surgeongeneral.gov/library/mentalhealth/home.html Accessed Nov 2004

Sayce, L. 2000. ***From psychiatric patient to citizen: overcoming discrimination and social exclusion***. Basingstoke: MacMillan.