

**TOWARDS RECOVERY COMPETENCIES
IN SCOTLAND: THE VIEWS OF KEY
STAKEHOLDER GROUPS**

**TOWARDS RECOVERY COMPETENCIES IN SCOTLAND:
THE VIEWS OF KEY STAKEHOLDER GROUPS**

Marguerite Schinkel
Nika Dorrer

CONTENTS	EXECUTIVE SUMMARY	1
CHAPTER ONE	INTRODUCTION	5
CHAPTER TWO	METHODS	7
Literature review		7
Focus groups		7
Interviews		8
Data recording and analysis		9
Limitations		9
CHAPTER THREE	LITERATURE REVIEW	11
Introduction		11
The role of recovery competencies frameworks in service development		11
Towards recovery-oriented services – the Scottish context		12
International frameworks for recovery competencies: USA		15
International frameworks for recovery competencies: New Zealand		16
International frameworks for recovery competencies: Australia		17
International frameworks for recovery competencies: England & Wales		18
Discussion of similarities and differences		19
CHAPTER FOUR	FINDINGS FOCUS GROUPS	23
Introduction		23
Competencies generated in the post-it task		23
Belief in and understanding of recovery		24
Facilitating respectful relationships		27
Challenging Professional Boundaries		33
Focus on strengths		34
Providing information		35
Care directed by service user		37
Involving significant others		41
Sense of humour		42
Providing holistic support		42
Community		44
Understanding and challenging stigma		45
Diagnosis		46
Peer support		47
Obstacles		49
Towards a recovery competencies framework for Scotland		51

CHAPTER FIVE	FINDINGS INTERVIEWS	53
Introduction		53
Occupational Therapy		53
Psychiatry		55
Social Work		56
Clinical Psychology		59
Nursing		60
Vocational Qualifications in Social Care		62
Tidal Model		65
Opportunities and pathways for change		66
CHAPTER SIX	CONCLUSION	69
Recovery competencies – the Scottish picture		69
Implementation		72
ANNEX 1		75
REFERENCES		77

LIST OF TABLES

Table 2.1	7
Table 2.2	8
Table 4.1	24
Table 4.2	75

EXECUTIVE SUMMARY

Aims and Background

This project aimed to lay ground for the development of a recovery competencies framework for mental health workers in Scotland by soliciting the views of key stakeholder groups. A number of recent Scottish policy initiatives support the move towards recovery-oriented practice. These include the Mental Health (Care and Treatment) (Scotland) Act 2003 and the National Programme for Improving Mental Health and Well-being and the related NHS programmes for action Delivering for Health and Delivering for Mental Health. While such a move needs to take into account a wide range of factors, such as the design of mental health services, the development of recovery competencies focuses on the skills, values, and knowledge mental health workers need to facilitate recovery. Recovery in this context does not mean that people are symptom-free, but that they develop “the ability to live well in the presence or absence of one’s mental illness” (Mental Health Commission, 2001). As recovery is an individual process, with individuals themselves defining what living well means to them, it is necessary to explore stakeholders’ experiences and knowledge before putting a recovery competencies framework into place. Whilst such frameworks have been developed elsewhere these need to be adapted to the cultural and service context in Scotland.

Methods

In order to learn from international approaches to recovery competency frameworks a literature review was carried out, focusing on frameworks developed in the USA, Australia, New Zealand and England. Publications related to mental health policy and service development in Scotland were also examined, to provide an overview of the Scottish context. To explore the views of different stakeholders, and to discuss findings from the literature review, eight focus groups were held: four groups with mental health service users (33 participants), one with carers (8 participants) and three with mental health workers (25 participants). To assess the possibility of implementing a recovery competencies framework in Scotland ten interviews were carried out with people in strategic positions in mental health training.

Key Findings

- The basis for recovery oriented practice is the ability to build up respectful relationships with service users, in which the worker has a genuine interest in the person, sees them as an individual, and takes them and their experiences seriously. Only within such a relationship is it possible for trust to be established. Service user participants in this study said that they also found it useful when workers share something of themselves in the relationship, thereby acknowledging a shared humanity and overcoming professional boundaries.
- It was highlighted that workers need to have a belief in and understanding of recovery, in order to be able to promote it. They have to understand that recovery is an individual process full of setbacks that can take a very long time, and remain motivated despite this.

- Participants found that recovery is promoted when mental health staff are good at listening, focus on people's strengths, and know when laughter may be an appropriate way to lighten the mood, create a bond in groups and help people to relax.
- Service users felt that having a say in their care is vital to recovery. To this end they need to be given more information, especially when they are first diagnosed, and where possible have different options for treatment and support. They should be allowed to take responsibility for their own choices and their negotiation of risk, whenever possible.
- Carers felt that they are often marginalised and not sufficiently involved or kept informed by professionals. If the service user wants significant others to be involved, workers should share information and take carers' knowledge and experiences seriously.
- Overarching themes were the importance of balance and timing. For example, a balance has to be found between creating safety and letting people take risks; between respecting service users' choices and decisions and facilitating recovery through challenging service users' boundaries. In these areas, there are no hard and fast rules and workers need to be able to reflect on their practice to resolve these issues.
- Participants thought it was important that mental health workers have had some experience of challenging life situations, are aware of their own mental health and support each other in their work.
- While some mental health training courses teach values that are in line with the recovery approach none have an explicit focus on recovery. Most interviewees felt that such an explicit focus would be beneficial.
- Participants had different opinions on the best format for training both new and existing staff in recovery competencies. Staff rotation, placements in service user-led projects, training in multi-disciplinary teams and being able to draw on other people's knowledge and experience of a range of services were considered important.

Obstacles to Recovery-oriented Practice

Participants considered the main obstacles to putting recovery competencies into practice to be overworked staff, a lack of time and resources, and a clash between idealistic training and existing work cultures. Finding respectful ways to overcome service users' lack of motivation also was considered to be difficult. An additional system level obstacle to the implementation of recovery competencies in practice is that the benefit system is deficit-focused, as is the majority of assessment tools used. There were also some concerns that the implementation of recovery competencies could be complicated due to the lack of a culture of self-determination and choice, and Scots not being comfortable with challenging professionals and demanding their rights.

Recommendations for Implementation

- Educators and focus group participants agreed that the successful implementation of recovery competencies will require support from government policy and the commitment of managers at all levels. There needs to be a consistent approach to change, so that mental health workers can see that recovery is an approach that has currency beyond being merely the next new initiative.

- It was proposed that, to overcome resistance from educators and practitioners, existing good practice has to be acknowledged. Promoters of the recovery approach should, furthermore, not take an anti-medical stance.
- Adequate supervision and support structures for staff were considered to play a crucial role in changing practice.
- A truly recovery focused mental health system needs more than a recovery competencies framework. Participants expressed the need for the development of peer support structures in Scotland. Service user input in the delivery of training courses and services was considered to be a significant driver of change. It was, therefore, suggested that infrastructures that support and reward real service user involvement need to be developed.

CHAPTER ONE INTRODUCTION

1.1 The project *Towards Recovery Competencies in Scotland: the Views of Key Stakeholder Groups* has been undertaken to lay the foundation for the development of recovery-oriented mental health services in Scotland.

1.2 The development of recovery focused practice involves a wide variety of stakeholders and any process of change towards recovery focused practice should begin with a consultation of these stakeholder groups. The present study sought to lay ground for the adaptation of recovery competencies frameworks to the Scottish context, bringing this process in line with stakeholders' needs and definitions. It aimed to do so through a) sharing international approaches to recovery competencies with mental health service users, carers, workers and educators and b) exploring their views on the development and implementation of a competencies framework relevant to the Scottish context.

1.3 The study sought to answer the following questions:

- What are mental health service users', carers' and workers' understandings and knowledge of recovery needs, including obstacles to having these needs met?
- What competencies do these stakeholders view as essential for the promotion of recovery?
- How relevant are recovery competencies frameworks developed in other countries to the Scottish context?
- What competencies have not been identified in the international literature or need to be adapted to a Scottish context?
- What are the views of people responsible for the provision of curricula and training for professionals working in the mental health field on the implementation of recovery competencies in Scotland?
- What barriers are there to the implementation of a recovery competencies framework in existing training courses?

1.4 The project design was informed by the recovery approach to mental health. Within this approach a central principle is that recovery from mental illness is different for everybody and is not just about the absence of symptoms. Unlike in evidence based practice, a recovery focused service does not rely on empirical evidence of the effectiveness of treatments or services as defined from a medical perspective. It takes as a starting point what recovery means to those who have at one point in their lives been diagnosed with a mental illness. To establish what competencies are needed to support a process of recovery, it is necessary to look beyond outcome measures such as reduced symptomatology and invest in an understanding of stakeholders' experiences and knowledge.

1.5 In Chapter 2, the methods used to answer the research questions are set out. Chapter 3 describes the Scottish context as well as material on recovery competencies frameworks drawn from the international literature. Chapters 4 and 5 outline the findings of the research project, generated by focus groups and interviews respectively. Finally, in Chapter 6 conclusions that can be drawn on the basis of these findings are discussed.

1.6 The current policy context in Scotland, the growing body of Scottish consumer led services and action groups, and the fact that training institutions and statutory services have commenced a collaboration with these groups, reflect that there are now many opportunities for a shift towards recovery oriented service delivery. While the findings of this project verify the existence of good practice and openness to change in Scotland, one of the aims of the present report is to identify possible obstacles and barriers that need to be overcome in order to put recovery competencies into practice. These are therefore discussed quite extensively in the findings sections. Also, the discussion of competencies inevitably went beyond necessary skills, knowledge and understanding and touched upon issues or concepts with an impact on recovery, often related to the environment in which workers practice. While these are not competencies per se, they are included in our report as they were seen as important by participants and often put the “proper” competencies in context.

CHAPTER TWO METHODS

2.1 This study sought to accomplish three tasks. The first was to review the international literature on recovery competencies. The second was to conduct focus group discussions with key stakeholders to explore their views on core recovery competencies. The third task was to interview educators and trainers with responsibility for designing and delivering courses in different mental health related disciplines to investigate how far recovery competencies are part of the existing training.

Literature review

2.2 A review of the international literature on recovery competencies was carried out to identify and compare different approaches. The Scottish context to recovery competencies was also explored. Government policy documents were accessed through the internet, and relevant peer-reviewed articles were identified and retrieved through the research databases Medline, PsychINFO and ASSIA. Search terms used were “recovery”, “competencies”, “mental health”, “best practice”, “care”, “service”, “model” and “framework” in different combinations. Searches using these terms were also conducted in Google, and journals considered to be of particular relevance, such as the Community Mental Health Journal, were searched issue by issue. In addition, relevant articles referenced in the Mental Health Nursing Review (Scottish Executive, 2006) and in Berzins’ review of the recovery literature (2006) were examined.

Focus groups

2.3 The second phase of the project aimed to investigate stakeholders’ views on recovery competencies for the Scottish context. A total of eight focus groups with three different types of stakeholders were conducted. Please see table 2.1 for a breakdown of focus group attendance.

Table 2.1: Characteristics of the 8 focus groups and number of participants per group

Participants	Organisation	Number of Participants
Service Users	Voluntary sector, service user forum/support project	6
Service Users	Voluntary sector, support and training project	9
Service Users	Voluntary sector, service user forum	7
Service Users	Voluntary sector, rehabilitation programme	11
Carers	Voluntary sector, information and support project	8
Mental health workers	Statutory sector, psychiatric day centre	9
Mental health workers	Voluntary sector, support and training project	8
Mental health workers	Statutory sector, community mental health team	8
Total		66

2.4 In order to minimise potential risks, all focus group discussions were conducted with established groups or teams so that participants were familiar with each other. In the case of service users and carers, groups that had a stated interest in being involved in service development were identified through internet searches and the Scottish Association for Mental Health. To explore as wide a range of views as possible, the selection of groups was further determined by their locations, which included an inner city and suburban area, a freestanding

town, and two rural areas, all in central Scotland. Teams of mental health professionals were interviewed within one NHS Board. See Table 2.2 for the professions represented.

Table 2.2: Professions mental health workers

Profession	Number of Participants
CPN	6
Student Nurse	3
Occupational Therapist	3
Support Worker	3
Social Worker	1
Undeclared	9

2.5 The findings from the literature were shared with the focus group participants through a presentation that provided a brief overview of the study, international recovery competencies frameworks and their similarities and differences. Prior to the presentation of the international approaches, participants were asked to write down two qualities that they thought mental health workers should have to facilitate recovery. This meant that there was some indication of which qualities the participants found important before being influenced by the researchers' analysis of the international literature. In the discussions following the presentation both the competencies generated spontaneously by the participants and the core principles and points of disagreement generated in the literature were used to prompt participants' views.

Interviews

2.6 In order to assess the views of people responsible for the provision of curricula and training for professionals working in the mental health field on the implementation of recovery competencies in Scotland ten interviews were conducted, including nine with people in key positions in the training of mental health workers. A senior nurse who was involved in the implementation of the Tidal Model on acute wards in Glasgow was also interviewed in order to reveal lessons learned from that process. The Tidal Model is an approach to recovery that focuses on helping people reclaim control in their lives (see section 3.10). In total, twelve people were interviewed in the ten separate interviews. These were:

- two occupational therapy university educators
- two consultant rehabilitation psychiatrists
- one learning & development advisor and one MHO advisor (social work)
- one local authority social work educator
- one mental health nursing educator
- one clinical psychologist
- one college educator in social care
- two college educators in community mental health care (social care)
- one City & Guilds advisor (social care)
- one senior nurse (Tidal Model)

2.7 Potential interviewees were identified either by others working within the mental health field (notably within the Scottish Recovery Network) or by contacting relevant agencies and

organisations directly. The six different disciplines selected (OT, psychiatry, social work, nursing, clinical psychology, social care) were considered to constitute core disciplines within the mental health field. Additional interviews within social work and social care training were conducted due to the existence of different training routes.

Data recording and analysis

2.8 All focus groups and interviews were audio-recorded with the permission of the participants and fully transcribed. Focus group transcripts were entered into the qualitative data analysis software package QSR NVivo and analysed line by line for their thematic content. Interview transcripts were analysed by both researchers and summarised. The written-up findings of this analysis were sent to all participants for feedback and to allow participants to check that their views have been represented accurately.

Limitations

2.9 Although efforts were made to source literature from non-English speaking countries, the recovery frameworks reviewed here are drawn from only four regions, namely the USA, Australia, New Zealand, and England & Wales. This is not to say that movements towards recovery-oriented service development are not underway in other countries. It may mean, however, that other countries have taken different routes towards system change or are, as in the case of Scotland, at a point where initiatives such as the development of competencies are yet in the early stages. In the case of non-English speaking countries the problem of translation of key terms arises, so that it may not be possible to identify the relevant literature by relying on the English terminology or straightforward translations of key terms. Unfortunately, due to the scope of the present project, it was not possible to establish contacts with key informants in non-English speaking countries who could have provided further insight into these issues.

2.10 While the project aimed to explore the views of a range of mental health workers, it proved very difficult to set up a focus group with professionals working in acute psychiatric care, within the time frame of the project and due to difficulties releasing staff to attend meetings. Additionally, only those mental health workers who had sufficient time and interest took part, which limited the number of professions represented in the focus groups, with psychiatrists and psychologists being especially under-represented.

2.11 Due to the scale of the project the findings are based on only a small number of participants and may not be representative of the views and experiences of all service users and carers in Scotland. Service users and carers in more remote areas in Scotland, which have not been included in this study, are likely to identify additional problems in regard to the care and support they can currently access. Due to ethical considerations the researchers also decided not to conduct focus groups with service users in more acute or intense service settings such as hospitals or supported living schemes. Another shortcoming is that the views of ethnic minority service users and carers have not been sought. It would be helpful if future research could explore the perspectives of people living in different geographical areas, from different ethnic or age groups, and of people who are at different stages in the recovery process.

CHAPTER THREE LITERATURE REVIEW

Introduction

3.1 The aim of this literature review was to examine international approaches to the development and implementation of recovery competencies. The review will firstly discuss definitions of the key concepts, ‘recovery’ and ‘competencies’, and the role of competencies frameworks in the facilitation of system change. In order to highlight the relevance of a recovery competencies framework for the Scottish service context, recent moves towards developing recovery oriented mental health services in Scotland are reviewed and potential obstacles to the implementation of a recovery approach to care identified.

The role of recovery competencies frameworks in service development

3.2 For the purposes of this paper, it is important to define what we mean by recovery, competencies and recovery competencies. Recovery is still a relatively new concept, which gained currency in the 1980s through mental health service users’ accounts of overcoming the debilitating effects of severe mental health problems (e.g. Deegan, 1988). Recovery as defined by service users counters negative conceptions of mental illness that focus on deficits and deterioration. Unlike in a medical context where recovery is often understood to mean a return to pre-illness functioning including a loss of symptoms (Dorrer, 2006), the recovery approach to mental health emphasises opportunities for the restoration of a person’s quality of life and positive identity (Bradstreet, 2004). Recovery is hence a liberating concept, which promotes optimistic attitudes and expectations (Anthony, 1993) and is focused on recovering abilities (US Department of Mental Health and Human Services, 1999). In this sense recovery has empowered service users and changed the way in which mental health is researched and services delivered (ibid).

3.3 Recovery is, however, also a disputed term, with some mental health service users objecting that it does not adequately describe their journey through mental health problems. Their main objection is that “recovery” implies that they have returned to the point from where they started when they first experienced problems, while they feel they have transcended their former lives or been transformed by their illness (Ralph, 2000). Another objection has been that the term recovery likens their experience too much to having a physical illness, thereby implying a medical model and forcing service users to accept that they were ill in the first place (Turner-Crawson & Wallcraft, 2002). Service users in Britain have felt that the language of recovery is a North American construct and that it would be better to use concepts that have been developed in Britain such as “strategies for living” (ibid.). Psychiatrists and service users alike have voiced concerns that the term recovery may exclude people who are (seen as) less able or willing to recover and lead to them being neglected and seen as failures, both by themselves and others (Torrey & Wyzik, 2000; Turner-Crawson & Wallcraft, 2002).

3.4 Despite these problems, the term recovery has been adopted in most countries to describe a new approach and vision of mental health problems. Recovery in this context does not mean that people are symptom-free, but that people develop “the ability to live well in the presence or

absence of one's mental illness" (Mental Health Commission, 2001). Crucial to this concept is that recovery is an individual process, with the person themselves defining what living well means to them. Also, recovery is not seen as an end-point but as an "an ongoing process of growth, discovery, and change" (Stocks, 1995).

3.5 In the context of health and care, 'competencies' have generally been defined as the knowledge, skills, and attitudes required by service providers for the delivery of high quality care (Chinman et al, 2003; Coursey et al, 2000a). Traditional competency sets tend to be profession specific and prioritise clinical knowledge and skills over interpersonal skills and attitudes (Coursey et al 2000). Recovery competencies differ from other competencies sets developed for the mental health field in that they prioritise values, attitudes and social skills and understanding. They are grounded in a philosophical approach to service provision (Sowers, 2005) and the recovery movement's broader mission of overcoming discrimination and promoting social justice (Torrey et al, 2005).

3.6 It is important to note that recovery competencies can only play a small part in the implementation of a recovery approach. On the societal level stigma needs to be challenged while on the service level the way mental health services are set up needs to be transformed. Recovery competencies can only work on the individual level, in attempting to change mental health workers' way of working and thereby facilitating recovery. Such an approach has the potential of making the values that are needed for a truly recovery-oriented service more visible and tangible (Young et al, 2000). Mental health system transformation has been delayed, Anthony believes (Anthony, 2004) not due to "the absence of critical science underlying our practices, but the absence of critical values underlying our practices" (p. 105). Indeed, the attitudes of mental health workers have repeatedly been reported to constitute one of the main obstacles to the successful implementation of recovery-oriented interventions (Young et al, 2005; O'Connell et al, 2005; Forquer and Knight, 2001).

Towards recovery-oriented services – the Scottish context

3.7 In the UK initiatives to implement a recovery approach to service delivery have largely been based on international mental health system reforms, predominantly those of the US and New Zealand. In 2001 the Department of Health introduced a recovery focus to mental health policy in England and Wales with a number of publications (DoH, 2001a, 2001b, 2001c). The notion of recovery also fits well with the European agenda for mental health. The *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions* (WHO, 2005) signed by the Ministers of Health in the European region of the World Health Organization addresses a number of the core elements of the recovery approach. In the document health ministers acknowledge that focusing on people's "strength and resources, reinforcing resilience and enhancing protective external factors" (ibid, p.1) should be the primary aim of mental health activity in Europe. The declaration proposes that the recognition of the experiences and knowledge of service users and carers, their empowerment and inclusion are fundamental to service development.

3.8 In Scotland a recovery approach to mental health is presently driven by the Scottish Executive's National Programme for Improving Mental Health and Well-Being. Within a policy context that centres on social justice and inclusion, the National Programme for 2003-2006

(Scottish Executive, 2003a) aims to function as a catalyst that guides and supports action for mental health improvement. One of its four key aims is to ‘support and promote recovery’. The development of the Scottish Recovery Network (SRN) is central in achieving this aim. The SRN defines itself as a ‘vehicle for learning and sharing ideas’ and brings together organisations and individuals in a debate on how to build the capacity for recovery in Scotland as well as carrying out primary research on the experience of recovery.

3.9 In addition to the initiatives of the National Programme a recovery approach to mental health is currently supported by the Mental Health (Care and Treatment) (Scotland) Act 2003 (hereafter referred to as the new Mental Health Act). The primary objective of the Act is to protect the rights of people with mental health problems, in which aspect it does not differ from the previous legislation (see also Berzins, 2006 for an overview). A fundamental difference between the new Act and previous ones is the introduction of guiding principles (Scottish Executive, 2003b). Although the Act makes no explicit reference to the promotion of recovery, both the principles and repeated emphasis on safeguarding the rights and benefits of service users endorse values of the recovery movement. It outlines ten principles as the basis for any action taken under the act. Of these, the principles of ‘non-discrimination’, ‘equality’, ‘respect for diversity’, ‘reciprocity’, ‘participation’, and ‘respect for carers’ in particular have direct relevance for a recovery-oriented mental health system.

3.10 The recent Mental Health Nursing Review (Scottish Executive, 2006a) has moved the recovery agenda forward by making the clear recommendation that a recovery approach is adopted in mental health nursing in Scotland. Many of its action points are related to implementing a recovery approach, including developing “a national framework for training in recovery-based practice to support the dissemination of recovery-focused models into practice” (ibid., p. 21) and involving service users and carers in the development of services and the selection of student nurses.

3.11 In December 2006 the Scottish Executive launched the implementation plan Delivering for Mental Health (Scottish Executive, 2006b), a key component of Delivering for Health (Scottish Executive, 2005), the overarching programme of action for NHS Scotland. This implementation plan, which includes a list of commitments and targets, makes specific reference to recovery approaches. Commitment 1 states that the NHS will develop a tool to assess services on the extent to which they are recovery focused. The NHS will also develop a training programme for people who themselves have direct experience of mental illness so that they are able to provide peer support to others experiencing similar problems as part of the care team.

3.12 In Glasgow, steps have been taken towards recovery-oriented practice by the implementation of the Tidal Model in pilot acute settings. The Tidal Model is “a philosophical approach to the discovery of mental health, focused on helping people recover their personal story, as a first step towards reclaiming control over their lives” (<http://www.tidal-model.co.uk>). It encourages practitioners to see mental illness as a consequence of the difficulties patients have experienced in their lives (Barker, 2001). Hereby, it acknowledges the importance of lived experience and the expertise of the patient in their own situation. The role of mental health nurses in the model is to help people to gain greater insight into their situation and to allow them to have a safe place where they can recover and gain strength. When the person is ready to return to a meaningful life in the community, care should be provided to help them to make that

transition. Early indications from Glasgow have been positive; with a significant reduction in the number of incidents (such as self-harm or complaints) on the wards, patients reporting better relationships with nurses and feeling more involved in their own care and nurses reporting greater job satisfaction (Lafferty & Davidson, 2005).

Potential obstacles

3.13 While there is wide-spread support for a move towards recovery-oriented practice in Scotland on a policy level, such a move will be challenging. First of all, assessments of current practice have found that, despite pockets of progressive service delivery, most practice in Scotland is still far removed from being recovery oriented. Grant's National Mental Health Services Assessment (2004) found an undercurrent of anger amongst service users and families about the care that they had received. Service users felt that they were not listened to, that there was an over-reliance on drugs in their treatment and that mental health staff focused on their diagnosis, rather than seeing them as a whole person. Carers similarly felt that they had not been sufficiently involved in the treatment of their loved ones.

3.14 Moreover, it is not yet clear whether there is motivation at the service delivery level to change direction and put recovery at the centre of practice. It has been found elsewhere that many psychiatrists are sceptical about the relevance of the concept of recovery (Roberts & Wolfson, 2004) and this seems to at least partly hold true in Scotland. In Glasgow, there were reports of lack of interest from both nurses and consultant psychiatrists in learning about the Tidal Model (Berzins, 2006). Grant (2004) found that the organisational culture of mental health service providers in Scotland in general was often one of inertia and hopelessness, due to perceived underfunding, increasing demands and continual negative feedback from service users. Even when mental health workers themselves are motivated and trained in recovery oriented practice, lack of support from managers can impede a shift in the right direction. Recovery training delivered by Working to Recovery and commissioned by the SRN was found to be less effective than had been hoped in cascading the recovery message throughout the services in which the trained professionals worked, because of a lack of support and understanding of the recovery paradigm on the part of their managers. Some people were unable to attend all of the training sessions because their managers were unwilling to release them for the whole time required. (SRN, 2006)

3.15 Lack of interest may be particularly relevant when initiatives are felt to be implemented in a top down manner and staff do not perceive them to be feasible or useful within a given care context (Young et al, 2005). This is why it is important to develop a context-specific recovery competencies framework for Scotland collaboratively, rather than imposing a framework developed elsewhere. In New Zealand the implementation of the Mental Health Commission's Recovery Competencies (2001) had been preceded by a long process of redefining an American recovery approach to a New Zealand context. A review of international frameworks for recovery competencies constitutes a starting point for an evaluation of what competencies may or may not be relevant to Scotland.

International frameworks for recovery competencies: USA

3.16 In the USA the concept of recovery was adopted by public mental health services in the 1990s (Jacobson and Curtis, 2000). At the same time efforts to develop psychosocial rehabilitation into a professional discipline led to an increased focus on the development of workforce competencies (Trochim and Cook, 1993). Such workforce competencies (e.g. Curtis, 1993; Trochim and Cook, 1993) were developed for the rehabilitation field but included competencies relevant to the consumer defined approach to recovery such as consumer empowerment and self management competencies, interpersonal skills that include the ability to offer hope and communicate a belief in recovery (Trochim and Cook, 1993), and an emphasis on creating recovery enhancing environments rather than focusing on just changing the individual.

3.17 In many ways the recovery approach as it has been developed in the USA may appear transferable to other countries. It is important to keep in mind however that the ‘culture of recovery’ (Mental Health Commission Ireland, 2005) evident in the USA today has been shaped by a variety of political, ideological and civil rights movements specific to American society. For example, many American models for a recovery based mental health system put a very strong emphasis on self-determination (e.g. Fisher and Chamberlin, 2004). This is a value that has its roots in the individual liberties formulated in the Declaration of Independence. The focus on self-determination at the cost of neglecting larger societal factors that play a role in recovery is illustrative of the continued prevalence of a culture of individualism in the USA.

3.18 The recovery approach that prevails in American approaches to service development today has been influenced by the characteristics of traditional self-help movements such as Alcoholics Anonymous (Sowers, 2005), the writings of consumer/survivors, and a shift towards community based and self-managed care models. Early recovery programs, such as the peer assisted healing programme developed by Recover Inc. in the 1950s, already focused on the skills of developing autonomy and empowering service users to take on responsibility for managing their illness (Sowers, 2005).

3.19 Peer support is a central concept in American recovery-oriented service initiatives (Sabin and Daniels, 2003). In this context, peer support goes beyond the support that arises naturally between people who have experienced similar difficulties and refers to more formal types of peer support, such as support groups, befriending schemes or advocacy projects (<http://www.mentalhealthconsumer.net/peer-support.html>). One of the most common types of formal peer support is that of self-help groups, where peers come together to support each other in a group setting often supervised by a professional counsellor. This constitutes a familiar concept in the States due to the long existence of self-help movements there. Another form of formalised peer support now also plays an important role in recovery oriented service delivery in the USA, with peer services being delivered by peers who are paid and work as part of the care team. Peers are trained and employed as expert patients due to their own lived experience of recovery (SRN, 2005). Due to the current lack of such peer support structures in most countries this dimension of competencies frameworks developed in the USA may be difficult to put into practice elsewhere.

3.20 Despite common strands there has been no national approach for the implementation of a recovery-oriented mental health system in operation (Anthony, 2000). System transformation

has instead been state specific, with different strategies adopted by individual states (Jacobson and Curtis, 2000). Similarly the development of competencies frameworks has not been coordinated nationally and a number of different frameworks have been proposed more recently. For example, Coursey et al (2000a, 2000b) and Young et al (2000) proposed competencies sets that consist of a mixture of clinical and recovery specific competencies, the core recovery elements in both sets being empowerment, hope, a holistic understanding of the client and their needs, minimising stigma, collaboration, family involvement and community orientation.

3.21 An influential and detailed recovery competencies model has been developed by the Ohio Department of Mental Health (1999). Ohio's *Recovery Process Model and Emerging Best Practices* has more recently been adopted by the National Institute for Mental Health England (NIMHE, 2004) and Northern Ireland's Mental Health Organisation S.T.E.E.R. While one of the disadvantages of the Emerging Best Practices model may be that its multiple layers make it very complex, it offers a detailed and practical description of the roles and responsibilities of the consumer, clinicians and community support workers. Fundamental values such as consumer directed care, a holistic view of the person, or the emphasis on hope are outlined as guiding principles for best practice. The recommended practice sets, however, consist of behavioural suggestions that are based on a stage model of recovery. The model proposes a process of recovery that consists of four stages ranging from a dependent unaware state to an interdependent aware state. The movement between stages is assumed to be non-linear but the end goal is one of optimal functioning and reconnection with the community. In addition to being organised into the four different stages and the roles of consumer, clinician, and community support worker, the practices are arranged into nine domains that are considered necessary foci of attention for recovery. These nine domains are:

- clinical care
- family support
- peer support & relationship
- work & meaningful activity
- power and control
- stigma
- community involvement
- access to resources
- education

3.22 One of the risks of such a detailed approach may be that it can be interpreted and administered in a prescriptive and mechanistic manner. However, the Ohio model for Best Practices also has a number of advantages. It acknowledges that different competencies will be needed for different stages in the recovery process. It provides a comprehensive guide to practices that should be carried out by all parties if a step-by-step progress towards interdependence is to be ensured. It recognises that competencies or practices are shared between consumer and care provider and that there is an interdependence between them.

International frameworks for recovery competencies: New Zealand

3.23 New Zealand has perhaps the most coherent national recovery competencies policy; it requires all mental health services to use a recovery approach and all mental health workers to be

trained in recovery competencies. In 1998 New Zealand's Mental Health Commission published a *Blueprint for Mental Health Services in New Zealand* followed by *Recovery Competencies for New Zealand Mental Health Workers* (Mental Health Commission, 2001) a few years later. These government initiatives had been preceded by a long process of redefining the US recovery approach to a New Zealand context. Central to this process was also the aim to pass ownership of definitions of 'recovery' to service users (O'Hagan, 2004).

3.24 The New Zealand framework consists of ten overarching competencies, which have been broken down into two to five sub-competencies, which are further elucidated with the use of examples. The competencies cover knowledge that is specific to the New Zealand context, but most of it is relevant beyond New Zealand's borders. The main competencies include:

- an understanding of recovery principles and experiences
- the ability to identify and support service users' strengths and resources
- an understanding of different views of mental illness and treatment
- the ability to build up good and respectful relationships with service users
- an understanding of and a commitment to protect service users' rights
- an understanding of discrimination and social exclusion and of how to reduce their impact on service users
- a comprehensive knowledge of community resources and a commitment to support service users to use these
- an ability to support service users' participation in services, informed by a knowledge of the service user movement
- an understanding of the importance of family and a commitment to facilitate their involvement

3.25 While *Recovery Competencies for New Zealand Mental Health Workers* (Mental Health Commission, 2001) breaks these down into smaller steps and provides reference lists for every competency that people can turn to for further information, the framework remains fairly philosophical. It does not give mental health workers specific resources to work with (such as the use of assessment tools or methods to get service users to engage and motivated) although it may point towards such tools in its examples, as in "the ability to use communication styles that motivate and support people to change" (ibid., p 15). This makes the New Zealand approach a demanding one; it requires mental health workers to be trained to a high level and to acquire far-reaching knowledge on both international issues and movements related to mental health and New Zealand policies and cultures.

International frameworks for recovery competencies: Australia

3.26 In Australia, the National Mental Health Plan 2003-2008 (Australian Health Ministers, 2003) aims to promote mental health and prevent mental health problems by increasing the extent to which mental health services adopt a recovery approach. The understanding of recovery in Australia has been mostly influenced by the US approach, along with examples of good practice in New Zealand, Canada and Australia itself (Rickwood, 2004). While the government has put recovery on its agenda, this has not yet led to a clearly stated, nationally adopted recovery competencies framework.

3.27 A model of working with people with chronic or returning mental health problems has been developed within Australia itself. The Collaborative Recovery Model (CRM) was initially devised by Lindsay Oades, a clinician in psychiatric rehabilitation, to integrate approaches to assessment and to make the experience of the client central to treatment (Australian Integrated Mental Health Initiative, 2005). In this model, change is initiated by motivating clients with enduring mental health problems to work on their recovery both through techniques such as motivational interviewing and through an assessment of their needs. On the basis of the identified needs goals for change are set collaboratively by the client and the mental health professional. These are broken down into small, achievable steps and the client is given homework so that their progress is translated into their natural environment (Oades et al, 2005).

3.28 Training has been developed to give mental health professionals the skills and competencies outlined by the CRM, and is being delivered through the Australian Integrated Mental Health Initiative (AIMHI). By 2004, staff in projects in Queensland, New South Wales and Victoria had been trained in the approach, with an evaluation being carried out by the University of Queensland (AIMHI, 2005). The model goes beyond other competency frameworks, in that it considers what specific tools professionals can use to initiate a move towards recovery when the client has internalised stigma, has low expectations and is not initially motivated to make changes.

3.29 However, another commentator from Australia warns that service users' lived individual experience should inform all recovery-based service delivery and that there should never be one set of guidelines for services to ensure that they are working in a recovery-oriented way, because this would further reinforce service delivery that works towards goals that can be objectified, instead of being open to the individual and flexible enough to allow them to discover their own route to recovery (Glover, 2005, p. 4).

International frameworks for recovery competencies: England and Wales

3.30 Similar to the USA, in the UK a shift in the way mental illness was viewed began with a move towards community based care, the rise of non-government organisations such as MIND and the National Schizophrenia Fellowship in the 1980s (DoH, 2001b), and the publication of the recovery stories of ex-service user mental health professionals and activists (e.g. Chadwick, 1997; Coleman, 1999; May, 2000). With the publication of *The Journey to Recovery - The Government's Vision for Mental Health Care* (DoH, 2001b) the context for system transformation was set in England. The vision outlined in *Journey to Recovery* does not in fact make any explicit commitment to promoting a recovery approach to mental health but lays ground for a transformation of mental health services through a redefinition of the roles of frontline staff and patients. Together with the reports *Shifting the Balance of Power within the NHS* (DoH, 2001c) and *The Expert Patient* (DoH, 2001a) the government put the empowerment of staff and patients at the very top of its agenda for change. There has hence been an emphasis on recognising service users' own knowledge and skills and involving them as active partners in treatment. Similar to New Zealand, there has also been a focus on the importance of improving the health of the local community through community development and meeting the wider objectives of social and economic regeneration (DoH, 2001c).

3.31 These government directions and the growing awareness of recovery in the UK have subsequently been translated into *The Ten Essential Capabilities for Mental Health Practice* (DoH, 2004). Developed jointly by the NIMHE and the Sainsbury Centre for Mental Health and in consultation with a wide range of stakeholders, it lays out a framework for the essential capabilities that everybody working in mental health education and care should have. ‘Promoting recovery’ is one of these ten capabilities. Each of the proposed capabilities is however in line with a recovery-oriented service system. The capabilities are:

- Working in partnership
- Respecting diversity
- Practicing ethically
- Challenging inequality
- Promoting recovery
- Identifying people’s needs and strength
- Providing service user centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development learning

3.32 The ten capabilities provide the basic principles upon which two further frameworks build, the Capable Practitioner Framework (Sainsbury Centre for Mental Health, 2001) and the Knowledge and Skills Framework (DoH, 2003). The list of ten capabilities is accompanied by a guide that breaks each principle down into specific examples of capabilities in practice. It sets high standards for the knowledge and understanding of mental health workers and their abilities to communicate these. In addition to these frameworks the NIMHE has proposed an adapted version of the Ohio *Emerging Best Practices* (NIMHE, 2004). Since the ‘emerging best practices’ proposed by the NIMHE have not been developed in consultation with local service users and care providers one may expect several barriers to their successful implementation. The strong focus on peer support inherent to the Ohio model, for example, may be difficult to put into practice since peer support is less well developed in the UK than in the USA.

Discussion of similarities and differences

Shared competencies

3.33 There are significant similarities in the recovery competencies frameworks discussed above. While often underlying principles are stated in different terms, or grouped together differently, some elements appear in all the frameworks.

3.34 The most basic, but also most fundamental of these is the need for mental health workers to have a **belief in and understanding of recovery**. Without a belief in the possibility of recovery, other competencies may be implemented but will not be delivered with a recovery focus and service users will not be given encouragement to work towards a life that they find meaningful. In understanding recovery, it has been seen as especially important that professionals understand that recovery is not a linear process and that setbacks will occur, so that they can help service users to cope with these.

3.35 **Respectful relationships** are seen in all the frameworks as a building block on which the rest of the interaction between mental health worker and service user depends – in these, it is important that service users are recognised as people in the context of their whole lives, values and experiences. Related to this is the need to **focus on service users’ strengths and capabilities**, rather than just concentrating on their diagnosis or other problems and deficits. This allows service users to see themselves as more than just someone with a mental health problem, encourages them to use their strengths, and can have a positive impact on their self-esteem.

3.36 For recovery to take place it is seen as crucial that service users have a say in the treatment they receive rather than being the passive recipient of mental health services. Rather than treatment being based on an assumption of what people need, **care and support should be directed by the service user**, based on what they perceive as their most pressing needs and goals.

3.37 **Challenging Stigma, Discrimination, and Social Exclusion** has always been a central objective of the recovery movement and also constitutes a core competency in all the frameworks. Mental health workers not only need to have a good understanding of the effects of stigma on mental health service users but also need to be aware that they or the service within which they are working may be perpetuating stigma and colluding with discriminatory practices. Mental health workers need to be able to support service users in coping with stigma and to help them to challenge and overcome discrimination and social exclusion.

3.38 **Significant others should also be involved in the recovery process** and be both kept informed and consulted, whenever the service user feels this is important. Significant others should be identified by the service user and can include a partner, family, friends and others.

3.39 To facilitate recovery it is important that support is not only provided with issues directly related to mental health, but also with any problems that may be exacerbating, or even causing, mental ill health. **Holistic services and supports should be provided**, which assess and tackle issues such as housing, employment, recreation, welfare and social networks.

3.40 Finally, it should be acknowledged that mental health service users should not have to live their lives within the mental health system. Instead, **community involvement** should be facilitated. This encompasses both involvement of the community in the service user’s recovery process, by encouraging the service user to access mainstream supports that exist in the community, and the involvement of service users in the community, by encouraging them to take up valued roles within the community, perhaps when they are further along in the recovery process.

Differences

3.41 As demonstrated above, the frameworks reviewed here converge on a number of important principles. There are also points of divergence. Differences exist in the way some principles are understood and emphasised, the degree to which competencies are specified, and whether they are tailored for specific professions or apply to the mental health workforce as a whole.

Accepting diagnosis versus service users' definitions of the 'problem'

3.42 Disagreements around the role of diagnosis or definitions of mental illness similarly exist in the recovery frameworks. In the 'Emerging Best Practices' of the Ohio Department of Health (Ohio Department of Health, 1999), for example, accepting one's diagnoses is a marker of the progress towards recovery. On the other hand, in New Zealand, one of the competencies identified in the framework is being able to "understand and accommodate the diverse views on mental illness, treatments, services and recovery" (Mental Health Commission, 2001, p. 41). This shifts the responsibility for reaching a consensus on the causation of the illness to the professionals; it is not the person who is experiencing mental ill health who has to accept her psychiatrist's diagnosis, but the psychiatrist who has to accept the person's view and to create a support and care package that is informed by and consistent with this view.

The balance between personal responsibility vs. social causation

3.43 All frameworks, as outlined above, address the impact of environmental factors on mental health in the form of stigma, discrimination and exclusion, and promote holistic services and supports. However, the different frameworks place different emphasis on personal responsibility and social causation. The New Zealand recovery approach acknowledges the social and environmental causation of mental illness and that often factors external to the person (for example, housing, family relationships or social injustice) need to change before recovery for the person can become a possibility. Other competencies sets favour empowerment through the facilitation of self-determination. An example of such an approach would be Oade's Collaborative Recovery Model (2004) where competencies largely focus on enhancing the motivation of service users and their ability to set and strive for goals. Making self-determination and personal responsibility a priority in the early stages of recovery may, however, be unhelpful. In the case where socio-environmental factors are preventing the person from getting well a focus on self-determination can easily instil a sense of failure.

Knowledge and provision of a diversity of treatments – facilitating choice

3.44 The ability to demonstrate knowledge of a wide range of treatments, including alternative treatments, providing education on these treatments and facilitating access to them, are not included as competencies in all the frameworks. The omission of such competencies may be due to the fact that access to a wide range of treatments is not a reality in some countries. Governments may also be hesitant to commit to the recommendation of treatments for which there is not yet a strong evidence base.

Emphasis on peer support

3.45 Differences exist further in regard to the emphasis on peer support. While detailed competencies involving peer support can be found in some of the US frameworks, references to peer support are absent in other approaches, for example the 'Ten Essential Shared Capabilities'. Peer support, informally and formally provided, plays a considerable role in facilitating recovery

(Brown & Kandirikirira, forthcoming 2007) but an emphasis on promoting formal peer support as a competency can be problematic if peer support networks and the infrastructures to support them have not yet been developed in a particular service context.

Emphasis on involving service users in service development and planning

3.46 The competencies frameworks reviewed here share a focus on service user centred care but not all state to what extent service user involvement should be encouraged. For example, is it part of mental health workers' responsibilities to ensure that service users are involved in the development, planning, recruitment and evaluation of services?

CHAPTER FOUR FINDINGS FOCUS GROUPS

Introduction

4.1 This chapter considers the service users', carers' and mental health workers' views on the findings of the literature review and their understanding of essential recovery competencies. It needs to be noted that, in the case of mental health workers, only a limited number of possible mental health settings were accessed. For example, no focus group was held with staff working in an acute mental health setting, as this proved impossible within the time frame of the project and due to difficulties releasing staff to attend meetings. All service user participants were active members of existing service user groups and could therefore be assumed to have travelled some way on their path to recovery. Any findings therefore need to be treated as an initial exploration of the issues under discussion, rather than as views that are held across groups and across Scotland. The headings under which the participants' views on, and experiences of, recovery competencies are reported below are based on the interpretation of the researchers. The competencies are organised in related groups and the order in which they are discussed is no reflection of their respective importance. Inevitably, discussion in the focus groups often went beyond actual qualities of mental health workers and touched upon other issues or concepts with an impact on recovery, often related to the environment in which workers practice. For example, while discussing the importance of mental health workers allowing service users to direct their own care, several participants highlighted that in the current mental health system there are often few or no choices available, which limits the extent to which service users can direct their own care. Often such issues were seen as important by participants and put the "proper" competencies in context, which is why they are discussed along with the competencies they relate to below.

Competencies generated in the post-it task

4.2 The desirable qualities for mental health workers written down on post-it notes by the participants in the focus groups were analysed by their thematic content and organised into categories. Table 4.1 provides a summary of the responses. A more comprehensive overview of the qualities proposed by the participants can be found in Annex 1.

Table 4.1: Frequencies and examples of competency categories generated in post-it task by service users, carers and staff

Competency	Service Users	Carers	Staff	Total	Example responses
Listening	12	4	9	25	Someone who actively listens to you Ability to listen interactively and critically People who hear what you say
Interpersonal qualities	13	3	9	25	Caring attitude Patience Humility – can learn from service user
Belief in and encouragement of change	11	2	8	21	Positive attitude A belief that recovery is possible Encourage to try again and keep going
Focus on the individual	6	6	3	15	Support that is personality appropriate To travel at the same pace as the individual Understanding that they were a person before they were a symptom
Empathy	6	0	5	11	I found helpful having someone to talk to who understands Empathy with people from different Backgrounds
Knowledge about illness, interventions and resources	8	1	2	11	Knowledge about mental health Give the patient a clear insight into his illness. Knowledge of available resources
Bring out person's strengths	3	0	5	8	Value the individual's potential Have the skills to get the best out of people Encourage me to take risks in improving my life
Life experience	5	0	2	7	Good life skills/experience Recovery from experience of mental health problems
Non-judgmental attitude	3	0	2	5	Open-minded, non-judgmental Non-judgmental attitude Non-judgmental approach
Sense of humour	2	0	1	3	Sense of humour
Others	9	0	0	9	
Total	78	16	46	140	

Belief in and understanding of recovery

4.3 A belief in recovery was unanimously seen as a crucial attitude for mental health workers. For service users, having mental health workers with a belief in recovery meant they should never receive a message devoid of hope. The statements about mental health people felt would be helpful, rather than detrimental, varied from “you will get over this” to an acknowledgement that certain symptoms may be life-long but that there are ways to cope and lead a meaningful life despite these symptoms. It was important to service users that mental health staff was hopeful, but realistic. People felt that hope for recovery should be present right from the beginning, even in acute wards, rather than only after release from hospital.

Pushing too much or challenging appropriately?

4.4 There was a lot of debate about how a belief in recovery should be expressed. Some service users spoke about the importance of staff being able to hold hope for them when they have no such hope themselves. Just having people who believe in their recovery around them made them start to believe in it themselves, eventually.

“I mean, I think a few months ago I wouldn’t have believed in recovery, but nobody stuffed it down my throat, it was just a continuous process of being held, while I was in a place of despair.” (Participant service user focus group)

At the same time, most service users wanted staff to be cautious about being overly optimistic and putting them under pressure to recover. People commented that sometimes it is not possible for them to feel positive, and that their mental health workers should accept this, rather than forcing them to have a positive outlook at all times. Also, having an overly optimistic mental health worker makes service users feel like they are not being understood, which makes them more likely to ignore what workers are saying. However, in three of the four service user focus groups people said that it can be very helpful to be challenged. Staff agreed that often service users have low expectations of themselves and need others to have higher expectations and to encourage them to fulfil these.

“A lot of the people who come here do have great potential, but sometimes don’t actually realise themselves that they have got that potential. They’ve been put down so much in their lives that they just don’t see it. But, maybe just stretching them a bit suddenly opens up a whole new world to them that they can move into.” (Participant staff focus group)

Ideally, this happens through a gradual building up of the types of tasks and responsibilities transferred onto people as they become more confident and with an acknowledgement that seemingly small steps can pose a big challenge. Service users should be supported to become aware of how much they are able to take on before it becomes too much and they get stressed, which could trigger a relapse.

Recovery as individual process

4.5 It was repeatedly stated that mental health workers have to realise how individual the recovery process is and that they should not think that the same type of support will lead to recovery for everyone.

“I think the problem with mental illness is that everyone’s different. There isn’t a hard and fast, as far as I’m concerned, route that everyone has to travel to recover, it’s very much an individual thing. There’s certain pointers you can put in to help along the way, but everyone is individual, every case is individual. There lies the bugger, that’s the problem with it.” (Participant service user focus group)

This means that mental health workers have to be very sensitive to the individual and their circumstances in promoting recovery. Timing, goals, activities and the expression of a belief in recovery all have to be tailored to or set by the individual.

Timing

4.6 When encouraging service users to move forward, mental health workers have to make sure that the timing is right, because whether someone is able to push their own boundaries will depend on how well or motivated they feel at the time. Therefore, when someone rejects the offer of an activity or support, this does not mean that the option can be withdrawn; instead it should remain available and be offered again. Mental health workers need to build relationships with service users so that they can assess when they are ready to move on or to engage with therapeutic interventions. Service users also felt strongly that mental health staff should not impose their own time scales for recovery on service users, or time-limit services they may need.

Achievable goals

4.7 Mental health staff and service users agreed that recovery often takes place over a long period of time, and that the steps on the way to recovery can seem very small. Some people felt that even maintaining their mental health on one level and staying out of hospital could be classed as being on the road to recovery, whereas others felt there was always room for some movement forward. Service users should have achievable goals to work towards and be able to set those goals for themselves, rather than being under pressure to “achieve recovery”.

“Sometimes just going outside the door is a risk. For you. And having somebody with you, just to go to the gate and go back home can make the difference.” (Participant service user focus group.)

When suggesting new activities and ways forward, staff should try to build on service users’ experiences, interests and background, rather than suggesting the same for everyone.

“I am quite arty crafty and I thought “I’ll go to the pottery” and then somebody told me “When you go to the pottery you make an ashtray”, and I thought for somebody that’s maybe okay, but it’s realising what you like doing. It’s like sticking you in a marathon if you’ve never run in your life before, you know, or you hate that.” (Participant service user focus group)

Reframing

4.8 Staff can also help service users by helping them to reframe situations that they evaluate negatively and to come to a more positive outlook. For example, one service user felt like a failure because she was feeling down and needed go and see her CPN again, but the CPN made her realise that being able to ask for help in this way was actually a strength and helped her to cope.

Staff motivation

4.9 Given that recovery is not a linear process and that people often experience setbacks in their mental health along the way, mental health workers have to be able to work with this and to remain motivated. As recovery is often a life-long process, change can be very slow. Participants in some of the staff focus groups said that this is difficult for them at times, especially when many of the people they work with are not achieving any of their goals or are taking such small steps that change is imperceptible.

“It’s challenging, and I think if you keep talking about it and staff are supporting each other, and allowing yourself to have days where feel frustrated or feel like you’re not contributing very much, I think that’s the challenge for workers. And I think that’s where supervision and staff peer support is really important. That we support each other to keep this vision.” (Participant staff focus group)

While many of the participants in the staff focus groups felt that they are already working with a belief in recovery, service users and carers often expressed the need for a culture change.

“I think they [mental health workers] can be very stuck. Very old fashioned in their outlook and looking at mental health as something there is no recovery from, and medication is the treatment.” (Participant carer focus group)

Problems of terminology

4.10 Finally, service users, carers and staff all commented that the term “recovery” can be misleading, in that it can suggest to people that they will get “better”, i.e. symptom free. Carers initially felt very hesitant about the recovery approach because they were worried that the people they were caring for would be encouraged to come off medication. One service user group was concerned that often people come to talks or events on the topic looking for a cure for their illness. To avoid this, the focus of the recovery approach on leading a meaningful life in the *presence* or absence of symptoms should be better publicised.

Facilitating respectful relationships

4.11 Two interrelated competencies that participants illustrated with many examples and that they described as fundamental to the recovery process were the ability to communicate respect and the ability to build a relationship with service users. The most frequently mentioned obstacles to the realisation of these competencies in practice were the upholding of boundaries between professionals and service users and a lack of people time and worker continuity. The skills that were considered to be essential starting points for establishing respectful relationships were empathic listening, a non-judgmental attitude, and the ability to see the individual person rather than “just another patient”.

Although the mental health workers and educators who participated in this study all stressed the importance of these essential skills, the carers, service users and some of the mental health

workers felt that they are not sufficiently practised, particularly not by mental health professionals in greater positions of power.

*“The professionals and the guys at the top need to look at the way they treat patients.”
(Participants carers focus group)*

Communication failure

4.12 The experience of not being listened to, either as service user or carer, was highlighted as a common problem in people’s interactions with mental health workers. Service users complained that mental health workers often take no time to listen, or only hear what they want to hear. They felt that their communication with mental health workers is frequently inhibited because they see themselves faced with preconceived ideas about their experiences or needs. Or worse, mental health workers impede interactions by failing to present themselves in an approachable and responsive manner. For example, participants reported incidents where staff avoided eye-contact or attended to multiple tasks at the same time, which discouraged service users from approaching them. A further problem is that ordinary rules of conduct such as introductions and a clarification of how one would like to be addressed are seldom exchanged at first appointments with professionals. Such inattentions reinforce the sense that professionals do not acknowledge service users as an equal person.

Power differences

4.13 The need to have an understanding and awareness of the imbalance of power in the relationship between service providers and users was very clearly expressed in the accounts offered by the focus group participants. Because of the experience of trauma and the context of stigma surrounding mental health problems, working with mental health service users requires a heightened awareness of how power dynamics impact on the way communication takes place. Service users and carers reported a persistent fear of mental health professionals, with people being too frightened to ask for help or to speak up. The prevalence of such fears demands that mental health workers engage in an analysis of their ability to control and influence service users’ wellbeing. As the voluntary service workers who participated in this study pointed out, communicating respect needs to begin with questions about power.

“Do I understand that in your life I might seem like a very powerful person, because in your eyes I might be able to deny you the service that we offer here? If you do something that pisses me off I might be able to influence your access to a psychiatrist who supplies you with your medication or other services - big power dynamic that sometimes I think we are not aware of.” (Participant staff focus group)

4.14 Some workers also pointed out that part of the problem is that service users themselves are not always aware when they are accepting a role that defines them as the unknowing patient and the medical professional as the expert who is in charge of the situation. Having accepted such a role, service users may not feel they are in a position to ask questions or to demand the clarifications they are looking for. Mental health workers should therefore consider it part of

their job to raise service users' awareness of how their perception of themselves as passive recipients of advice and the professional as a figure of authority will impact on the way communication takes place. Mental health workers should support service users in challenging debilitating role definitions.

Establishing trust

4.15 Several participants emphasised that the foundation for a collaboration between mental health workers and service users needs to be established right at the first contact, which in many cases takes place when people are admitted to hospital due to an acute episode, especially as service users and carers are likely to make the contact at a time of great distress and uncertainty. What people need most from mental health workers during this time is the assurance that they or their family member or friend are going to be safe and that their interests will be respected. This means that mental health workers need to take every care to be open and responsive to people's concerns rather than letting service procedures and formalities take precedence. Without respect, consideration and openness from the very beginning, participants said, it would be impossible for carers to trust that their family member or friend is in a safe place and for service users to trust that suggestions from staff are in their best interest. Trust subsequently needs to be built through keeping people informed about all proceedings, involving people in decision making, having discussions about what staff's and service users' responsibilities are, and allowing service users to take steps towards recovery even if these may put them at risk of relapse.

4.16 Several participants stressed that creating an atmosphere of trust depends not only on the way mental health workers relate to service users but also the way in which the staff of a service relate to each other. Having the opportunity to observe staff interacting with each other in a responsive, open, and emotionally consistent manner helps service users to feel safe. Service users further noted that they are more likely to trust in a mental health worker's ability to offer them support and advice if they can observe that they are aware of and able to manage their own psychological well-being.

The ability to empathise: seeing and understanding the individual

4.17 Empathy, defined as the ability to understand and identify with service users' feelings, difficulties, and backgrounds, emerged as an important quality in the post-it task. In the focus group discussions, a basis for emphatic relationships was frequently seen to be a genuine interest in getting to know the individual person and who they were prior to falling ill. To be understood as a person was of primary concern to the majority of participants.

“The illness is not the number one goal. The number one goal is you. Your mental health illness is second, not first.” (Participant service user focus group)

4.18 In order to be able to offer the individually tailored support highlighted in the discussion of 'recovery as individual process' above, mental health workers need to know people in the context of their prior interests and their life experiences. This not only requires mental health workers to make time to listen to service users and carers but also to aim at gaining a deeper

understanding of what experiencing mental health problems is like for the individual person. Non-judgmental empathic listening was considered to be essential to understanding the needs of service users.

“I think, everyone is individual, reacts to different situations and I’ve always felt that if they were a bit more empathetic and listened a bit stronger to what I was saying, rather than what they actually wanted to hear, then my recovery may have been speeded up”.
(Participant service user focus group)

Service users and carers suggested that by understanding the significance of service users’ experiences, mental health workers may be more able to uncover latent or new ambitions and to encourage people to pursue these. Tapping into service users’ interests in this way makes it more likely that they will be motivated to take their first steps towards recovery.

4.19 Some participants pointed out that empathic listening also needs to include a ‘listening’ to people’s behaviour by watching and observing patterns of their ups and downs.

“When I came here, there was ordinary verbal listening, but there was listening to body language and listening to what I did. Listening to what time I came in in the morning, and then people were making connections and then giving me challenges.”(Participant service user focus group)

Service users felt that it makes a real difference when mental health workers can tell by a person’s face or body movements that something has distressed them without them having to verbalise anything. More importantly, if mental health workers have a good knowledge of the person then they are able to tell whether a response is normal for them or an indication of an underlying problem. By feeding their observations back to service users, mental health workers can support people in learning to monitor and manage their symptoms and difficulties.

4.20 The ability to listen to people in this way was also seen to be important for getting the right balance between confirming that their current way of feeling was justified and the expression of optimism. As has been discussed above, workers who communicate an optimistic view regardless of how a person feels about their illness will risk being perceived as lacking empathy. However, the collusion with the service user’s outlook was also not considered to be helpful. Workers need to be able to empathise with a person’s experiencing in a way that helps them to move on.

“I think it is a mixture, because it’s like if you are too positive it feels like the person doesn’t understand you. They don’t get where you are at. Whereas if you were totally to collude and say ‘well yea that’s pretty rotten isn’t it’ then you would feel totally hopeless. It’s almost like saying ‘yea’ like listening and sort of experiencing what the person is going through and saying ‘yea obviously I can see you are really upset it must be really difficult for you but how can we get beyond this’.” (Participant service user focus group)

Taking service users' and carers' experiences and views seriously

4.21 It was extremely important to service users and carers that their views and experiences were taken seriously. Mental health workers need to be able to relate to the significance that certain experiences or feelings have for people. They need to take care not to suggest that they have a better understanding of the person's experiences or a superior knowledge of what may help.

*"There has to be a faith that very often unless somebody is extremely ill the person has their own insight they know themselves what might help or what might not help."
(Participant service user focus group)*

Service users gave numerous examples of how mental health workers remained unresponsive to their attempts to change their care and treatment according to their own observation of their progress. The participants' examples included service users feeding back to professionals that their medication isn't working, that they are in need of crisis support, or that they aren't ready for a particular therapy or a return to work. Carers similarly felt that mental health workers did not acknowledge that they are in a good position to judge whether a particular treatment or intervention is appropriate for their family member or friend at any given time. There were, however, also positive examples such as mental health workers trusting that service users are able to judge whether they are ready to take risks, or the offering of immediate support through listening without questioning.

4.22 Participants in the staff focus groups acknowledged that there is always a danger of imposing your personal expectations onto service users. Expressing a critical view of somebody's position in society, even if this is done in an effort to encourage people to move on, can amount to disrespecting people's lifestyles or choices. Maintaining respectful relationships with service users means that mental health workers need to be very careful when making any suggestions about what service users should expect from themselves.

*"It would be just as wrong to say 'well leave your flat, leave your husband, leave your wife, go and do something else' cause that would, you'd be giving them the life you'd want, so it wouldn't matter how hard it is, you are making decisions for people. Because they just don't get their own life then they get yours."
(Participant staff focus group)*

Continuity and frequency of contact

4.23 Although the importance of building a supportive relationship and getting to know each service user as an individual person was acknowledged by all participants, in practice, a lack of worker continuity and people time prohibits the building of such relationships. Service users as well as mental health workers drew attention to the detrimental effects of frequent staff changes, such as service users feeling stuck because they have to negotiate an understanding of their needs repeatedly or adjust to a completely new approach.

"See the change upsets me. What upsets me is, I get CPNs, right, I've got four or five of them and that's just a nuisance. Now, I've got a new CPN and that takes getting used to."

Who is she? What does she belong to? Can I trust her? Because you've got so used to the other one. But it seems now that they are shifting them all over. You can only keep them so long and then you have to start over again. And that's upsetting for people with a mental health problem.” (Participant service user focus group)

The lack of continuity was seen to be problematic especially in relation to those health professionals who people only see every couple of months, like their CPN or their psychiatrist. As these health professionals have little opportunity to observe patterns of wellbeing, they are not perceived to be in a good position to make suggestions about changes that could contribute to a process of recovery.

“You see a doctor, or a CPN or a psychiatric person every couple of months. They don't know what has happened between those months. I mean, I could go through a really bad dip and then come back out and then the CPN says ‘But you're fine!’.” (Participant service user focus group)

Contributing to the fragmentation of some professional's knowledge of the service user was seen to be the lack of continuous information exchange between mental health workers. There is a need for more effective interagency working to ensure that everybody involved in the support of a person is up to date with developments in their recovery and the objectives of their care plan.

4.24 Despite these issues, several service users also identified good aspects of switching to new mental health workers from time to time. Having your mental health workers change over was seen as an opportunity to draw on people's different skills, knowledge, and perspectives; the chance “to come up against something different”.

4.25 Service users were aware that it is unrealistic to expect mental health workers to be there always and forever but felt that there should be greater transparency in relation to staff changes. In holding with a respectful attitude towards service users' apprehensions, service users need to be given clear information about what to expect and should be told in advance if there is going to be a staff change so that they have time to adjust.

4.26 Overwhelmingly, service users felt that the belief that frequent staff rotation is necessary to prevent dependency and attachment was unjustified and was hindering recovery. Mental health workers should have faith in service users' ability to understand the risks of, for example, becoming reliant on the support of a person. Service users felt they are able to distinguish when they are interacting with somebody on a working or a friendship level and know not to overstep boundaries in this context. Most of all, there should be a willingness to talk about these issues.

“Particularly in the NHS, there is a professional fear of attachment. And the logic is that it induces reliance. In actual fact, to recover, you actually need somebody to build a relationship with you.” (Participants service user focus group)

4.27 In the focus group with members of staff from one of the voluntary sector projects, a different solution to the problem of providing worker continuity without risking that people become reliant on just one person was presented. Within the project, continuity is guaranteed not

on a one-to-one level but through working closely as a group, with everybody maintaining a good knowledge of the issues affecting both service users and members of staff.

Challenging Professional Boundaries

4.28 In the majority of the focus groups, it was felt that the development of respectful and recovery-oriented relationships is inhibited by the upholding of professional boundaries. The boundaries that participants had encountered consisted of staff, often inadvertently, maintaining a distance between themselves and service users, creating an atmosphere of “us and them”, and there being an unequal appraisal of expert and patient knowledge. Mental health workers also noted that there were hierarchical boundaries between professional groups, with some workers’ contributions to care and their knowledge of the individual person not being fully acknowledged. The hierarchy created by professional boundaries undermines attempts to establish respectful relationships and limits the extent to which working in partnership can be realised.

Acknowledging a shared humanity

4.29 Boundaries can be upheld through addressing service users by their first name while professionals are addressed with their full title. Although some mental health workers pointed out that this was common practice across all service contexts and that it was deeply ingrained in society, other participants felt very strongly that a discussion of what people wanted to be called should take place in order to lay the ground for a respectful relationship. Participants also felt that medical professionals appeared at times reluctant to share their knowledge with service users, therefore setting themselves up as the expert and the service user as a passive recipient rather than a partner in care.

4.30 Regaining a sense that they are a worthwhile person is for many an important step in the recovery process. A competent mental health worker will therefore be able to communicate to people that, despite different life experiences, professionals and service users have many of the ups and downs that are part of life in common. Through this recognition of their shared experience of being human, service users and professionals should find themselves very much on the same level. This was indeed how people felt about two of the projects at which focus groups were conducted:

“The staff and the manager in here are very very supportive too. We are just one big happy family. Because people who come in here and they’re speaking to the manager, they wouldn’t know who the staff is. They wouldn’t know the difference between the member and the staff.”

The only difference between the members and the staff is, the staff get paid for it.

Well, we get paid. We get paid in other things. Knowledge, understanding, respect.”
(Participants service user focus group)

The exchange of personal information

4.31 The question whether mental health workers should disclose information about their personal life generated a lot of discussion amongst focus group participants. Many of the participants felt that some exchange of experiences and feelings improves service user-worker relationships. As one of the participants pointed out, when somebody asks you for help or talks to you about themselves it means an affirmation of your worth.

4.32 Participants agreed that there is helpful and unhelpful self-disclosure. For example, although service users felt that they get on better with somebody who is willing to give away something about themselves, it is unhelpful if workers project their own experiences on the service user or self-disclose in such a way that the service user feels they need to provide support. Self-disclosure was seen to be helpful if its objective is to offer reassurance about workers' perspectives and backgrounds or when the related experiences can be used as a mirror for the service users' current difficulties. Again, the need to be attuned to the service user and to have established a trust relationship in order to be able to judge when the offering of personal experiences can contribute to a person's progress of recovery was highlighted.

“It [reciprocity] is useful if it’s in the right place. I think the worker has to know you well enough or to understand what you are going through well enough to make that judgement. And again, you would need to have a relationship and trust built up by that point. [...] There’s no harm in trying, sort of thing. But you have to be in the right space to be able to deal with it.” (Participant service user focus group)

4.33 The majority of the mental health workers shared the view that self-disclosure could be very useful on some occasions. From their perspective, it is appropriate for establishing common ground if it involves past experiences that have been sufficiently processed and are similar to the service user's current situation. Mental health workers need to have a sense for when sharing their story has the potential to help service users understand their own.

4.34 The risks of sharing experiences with which workers still struggle themselves could, however, outweigh the potential benefits. Due to concerns about safety for both service user and worker, they felt there were clear limits to how much they would disclose about themselves, for example, they would not disclose details of their contact details. Service users and workers acknowledged that there are different levels of self-disclosure that people feel comfortable with and that this needs to be respected by both parties. However, even some basic information about workers' personal lives can go some way towards establishing a more equal relationship between service user and professional.

Focus on strengths

4.35 Participants felt that it was essential for the recovery process that service users are not reduced to a diagnosis in their own eyes or the eyes of others.

“The most important thing: when you’ve got a mental health problem, you have to believe in yourself. You have to say “I can do that”. You’re not a dumblet, as people call people with

mental health problems, a loony. You're a person. I am a person. I have the knowledge in myself to believe in myself. I am a person." (Participant service user focus group)

Mental health workers therefore have to actively encourage people to see and use their strengths and abilities. Service users often have not had the opportunity to contribute to anything in a long time, always being at the receiving end of care and support, and may first need help to build up their confidence again. Enabling people to utilize their skills and contribute to the running of a service can have a big impact on their self-worth. People may have to start off with small tasks, but their input can be increased over time.

"But when you come here and feel "I can't do that" everyone else will tell you "Yes you can". "But I can't give 90%", people will say "what about 5% today"." (Participant service user focus group)

4.36 Staff noted that they are hindered in bringing people's strengths to the fore by deficit-focused assessment models and welfare forms they have to work with. For example, benefit forms always focus on impairment.

"I think most people know that filling in a DLA form with somebody is one of the most disempowering experiences and is not something you look forward to doing because the person feels dreadful, you don't feel great and chances are you won't even get it first time, anyway." (Participant staff focus group)

Providing information

About mental health problems

4.37 Service users and carers expressed the need for education and information upon diagnosis. People often have no prior knowledge of mental health problems, may never have heard of the diagnosed illness or have the same stigmatising understanding of certain conditions as the general public. This means that receiving a diagnosis can be bewildering as well as devastating for people's self-image.

4.38 Many participants in the service user focus groups felt that they had not been given enough information when they were diagnosed about what to expect from their illness. In some cases psychiatrists even failed to give them their diagnosis, which prevented them from accessing relevant information themselves. Carers often felt left out of the loop and, faced with diagnosis of severe mental illness, sometimes fell into a "black hole" in which they lost all hope for their loved one. However, there were also positive examples.

"I said to one of the nurses, my named nurse, that I had a child and that I had to be able to talk to him. And she gave me some literature that was really simple, which I read and then I talked to him about it. (...) It's changed him somehow, but because there was a proper explanation at the time and because he was brought in. I think if that is done sensitively, that is very very good." (Participant service user focus group)

4.39 Participants said that being given appropriate information helps them to know what to expect, which means that they may panic less when symptoms occur. In addition, knowing more about the mental health problem and being given a positive message can help in preventing or overcoming internalised stigma. Carers also need to be given more information in order to be able to support their family member or friend once they are discharged.

4.40 Information needs to be given in the right format and at the right time; service users said that “being bombarded with booklets” was unhelpful. It is also important that the information and prognosis provided are hopeful but realistic. Service users said it helps them to know that some things are just part of their illness and not within their power to change; they sometimes feel like a failure when symptoms return, and knowing that this is beyond their control helps them to accept their condition and themselves. Also, having realistic information prevents people from building up false hopes and expectations.

“Sometimes being unrealistic sets people up to fail if you say ‘Oh yes I’m gonna do this and this and this and this’, how is the person going to feel in four weeks time when not only none of that happened but then they are so depressed about it not having happened that they feel worse.” (Participant staff focus group)

About other issues

4.41 Carers and service users felt that they are often not given enough information about medication and alternative approaches to mental illness. One group said that GPs should know, provide information about and have access to a range of psychological interventions, rather than just prescribing medication and referring people to psychiatrists. The same group felt that they, as service users, often know more about new (policy) initiatives or approaches, such as recovery or Choose Life, than front-line mental health staff, who do not get the time away from their work to learn about new directions in mental health. One carer gave an example of how she had to find out herself that alternative medication for her daughter was available and suggest a change in medication to the psychiatrist. She felt that it was his job to keep up to date with developments and suggest alternatives, especially as the medication her daughter was prescribed was not very effective.

4.42 Participants in the staff focus groups felt that they should not be expected to inform service users about all developments in human rights or the Mental Health Act as there are designated community agencies in place to provide advice on such issues. They thought that, rather than setting staff up as all-knowing experts, it is better to refer people to such community agencies, because this encourages people to help themselves.

4.43 Service users and staff from one of the voluntary projects that participated in this study placed a lot of emphasis on information sharing. In their organisation information is collected on a wide variety of relevant topics and made available in folders to anyone who is interested. They have a wide range of self-help materials which service users are encouraged to use and organise discussion groups about topics that need addressing at the time, such as anxiety management. Service users and staff often go on training courses together and then share what they have learned with the rest of the group.

Care directed by service user

4.44 All participants agreed that it is very important for care to be user led. For service users, being offered options, information (as discussed above) and ongoing advice, rather than being prescribed treatment, makes a significant difference in their process of recovery. In fact, for many the realisation that they have choices and can be in control of their care marked the beginning of their recovery. Ideally, service users should be encouraged right from the start to take responsibility for their own choices and to make their own decisions. Mental health workers should not make decisions for people, unless someone's safety is at stake.

The gradual building up of shared decision making

4.45 Service users and staff acknowledged that there needs to be consideration of what constitutes the right time for a person to be asked to make their own choices in regard to care and treatment. As one of the mental health workers described it, if someone is very unwell it can be about a gradual building up of how much service users are involved in decisions.

“Sometimes people are in a place where they feel just desolate and at that point they need people to care for them and support them and they are not necessarily directing very much at that point.” (Participant staff focus group)

While mental health workers may need to initiate changes for people in the early stages of recovery, their role should subsequently be one of providing information and choices, and offering guidance in decision making.

Goal setting and negotiating support needs

4.46 Important elements of user directed care are the collaborative setting of achievable goals and an ongoing negotiation of support needs. Mental health workers acknowledged that it is often a waste of time and effort to try to get service users to engage with activities and/or support in which they have no prior interest. In order to make care user led, mental health services and workers need to be able to adapt themselves to the individual needs of the person.

“A lot of cases are: this is what we've got, how can we squeeze this person into what we've got. It should be: this is what this person needs, how can we change our services to suit this person.” (Participant service user focus group)

4.47 Service users felt it is important that mental health workers do not put pressure on them to perform and achieve targets consistently but adjust their expectations to the ups and downs that are characteristic for the recovery process. Service users felt strongly that care plans should accommodate their need to try different things in order to find out what works best for them without having to fear that treatment or support offers are going to be withdrawn. Being granted such flexibility was seen to be important especially in the context of finding the right medication or wanting to come off medication.

“[My doctor said] ‘Ok right I don’t think you should take anything just now if you feel you can cope but we are still around in two months time if you feel any different’ and that was amazing, that was really good. Any other experience I have had it was just ‘here and now’ if you don’t act now then there will be no kind of future or come-back from it.”
(Participant service user focus group)

Even when service users have reached a level at which they are largely self-managing their care by drawing on a wide range of holistic therapies and self-help techniques, as was the case for some of the participants, having access to statutory support was still important to them.

4.48 Mental health workers had some concerns that due to the ups and downs of people’s wellbeing it is not always possible to go along with what they request at any given time, especially when service users seem to lack insight. How people want their care to be managed can also change depending on whether they are going through a high or low episode. Service users were, however, aware of the potential inconsistencies in their decision-making and gave examples of possible safeguards. One participant explained that in the course of discussing the pros and cons of changing medication she and her psychiatrist made a “verbal pact” that they both needed to agree on further reductions in medication within a specified trial period.

Power and review practices

4.49 The most frequently cited obstacle to service user directed care was the perceived authority and control of mental health professionals, and the service users’ lack of confidence to contribute actively to care planning, as discussed above. Also, current review practices can be very disempowering. Often reviews are held in hospitals and service users are asked to speak up in front of a large group of professionals who they might not know well, which staff flagged up could be an intimidating rather than empowering experience. Ideally, service users should have significant input into the agenda of the meeting, its location and who will be invited so that they have control over the process and can create an environment in which they will feel comfortable to contribute.

The negotiation of risk

4.50 Service users felt that they are not always allowed to make their own decisions, especially if these involve some degree of risk, as defined by mental health workers. This risk-averse way of working in mental health was mentioned as a huge inhibiting factor to user-directed care and recovery itself by most focus groups. Participants compared the risk culture in Scotland unfavourably to that in other countries and felt that staff, and especially staff on hospital wards, spend a lot of time on risk-management which is irrelevant or unhelpful to service users.

4.51 Service users asserted that, by and large, they are capable of assessing risks themselves, unless they are extremely ill. They felt that staff sometimes impose their own values and norms on service users; labelling something as risky behaviour just because it is not within the range of what they perceive to be ‘normal’ behaviour.

“That holds people back, and that’s the thing that is a really big barrier, staff not wanting to take risks as they see it. You may not see it as a risk, you might just see it as a development or something, a challenge. Life is about risk and if you’re not allowed to take risks then you’re not having a full life, and that is a big challenge at the minute, I think.” (Participant service user focus group)

4.52 Carers agreed that mental health workers are often not willing to move things forward and that therefore service users get stuck. They felt that this sometimes is because keeping things as they are is easier and less work for staff.

“There’s a sense even in the community, not necessarily just in hospital, that care workers are there for containment, almost, to keep things safe and at the status quo, just leave it as it is, it’s alright when you get like that, there’s no push forward ever, and that’s the culture that needs to be changed.” (Participant carer focus group)

Limitations of user directed care

4.53 For care to be directed by service users, mental health workers need to be prepared to accept and support service users in their choices. For some mental health workers, service users’ rejection of the medical approach can be difficult to accept, and for others it can be difficult to work with the service user’s choice to rely on a medical approach. In some cases, however, mental health workers will consider it necessary to challenge service users’ choices or views, for example when a person does not acknowledge that their substance abuse constitutes a significant barrier to their recovery.

4.54 Mental health workers noted that treatment orders significantly limit the extent to which they can work collaboratively with people. By definition care delivered under a treatment order is not user led. Promoting the empowerment of people sectioned with a treatment order by working with the values of recovery was nevertheless seen to be crucial.

“Sometimes people have been in a situation where their authority, their ability, their illness has been such that they have needed statutory measures, and so then trying to empower someone when you have taken away all their rights and power, it’s quite hard. But I still think it’s possible to work using these values and using the philosophy behind it.” (Participant staff focus group)

Lack of choice

4.55 In focus groups with service users, carers and staff, the lack of choice in the mental health system was flagged up as a problem to service user-directed care. Often only one type of service is available, and services are constrained in what they can do for people because of funding arrangements. Service users also generally have no choice of psychiatrist or other professional, which can be really unhelpful if they have a negative relationship with the person they have been referred or assigned to.

Support agreements

4.56 To ensure that working in partnership is successful, both parties need to be aware that there can be conflicts of opinions that require respectful negotiation. Participants repeatedly stressed the importance of openness, clarity and accountability when working collaboratively. Several service users and carers suggested that a support agreement should be put into writing at the beginning of a working relationship. Such an agreement should not only spell out confidentiality rules but define what each party can expect from the other and what they need to be aware of when working together.

“Like we were saying a code of conduct saying where my boundaries are and also the mental health worker’s boundaries, they are going to have boundaries as well, they might have issues as well and if I overstep them it might make them feel uneasy with me. So I think there is need for reassurance about mental health worker’s perspectives, backgrounds, how they feel, why they react in x way, what they boundaries problems are that one may be tapping into.” (Participant service user focus group)

Advocacy and service user representation

4.57 Participants confirmed that many service users are not aware of their rights and are not always informed about them when admitted to hospital. Service users’ fear of being seen as “trouble” often keeps them from inquiring about their rights. Service users and carers felt there is a need for increased access to information about rights and for raising people’s awareness that the principles spelled out in the new Mental Health Act are not optional but constitute legal entitlements.

The Mental Health Act and this whole thing about participation, it’s a right. It’s not just something that somebody says ‘Oh would you like to?’ It’s a right.” (Participant service user focus group)

4.58 Although service users pointed to the advantages of having somebody who advocates their rights and views, mental health workers reported that the uptake of advocacy services has been limited. Mental health workers need to be aware that it can be difficult for service users to confide in a stranger and to understand that the advocate is working independently from the mental health services they are using.

4.59 Similarly, mental health workers believed there are still significant obstacles to the facilitation of service user representation in the design and planning of services. A particular challenge is to include the views of people who may not feel able to get involved in meetings and to prevent that service development is “led by one or two individuals who feel well enough and are articulate enough to design services” (participant staff focus group).

Involving significant others

4.60 Service users and carers felt that having significant others to support you makes a huge difference for people with mental health problems, and speculated that many people may never enter the mental health system because they have such a support network in place. Everyone agreed that, if the service user so wishes, significant others should be listened to and involved in care planning from day one. It was felt that carers need honest feedback, and up-to-date and accurate information in order to know how to support their family member or friend. When people are first diagnosed, some information on what to expect and how to react was seen as very helpful, but often this is not available.

4.61 Carers felt very strongly that significant others are often ignored by people working in the mental health system, even though they have much to contribute. They have knowledge of the person before they started to experience problems and of the subsequent development of these problems. Carers can also provide feedback on people's preferences and needs if they are not able to communicate these themselves. At the moment carers often feel they are "treading on eggshells" when making suggestions to staff. They fear that after having worked very hard to get "a foot in the door", the door might be shut on them if they 'annoy' staff. There is also the fear that being seen as pushy or critical by staff might have repercussions for the person they care for.

4.62 Mental health workers should be aware that coming to mental health services is often a last resort after a long period of trying to cope without professional help. Support for carers themselves should be made more available, as they too need help and feedback to deal with the impact of a mental health diagnosis. Without this they often get trapped in a carer's role without much hope for development or change.

*"I think carers themselves need a lot of support in helping them look at the whole kind of web that's set up, the relationship they get locked into, because of the system."
(Participant carer focus group)*

4.63 Some service users had reservations about their significant others, especially their family members, being involved in their care. For some people the relationships they have with family members contributed to the development of their mental health problems. Other service users felt that their relationship with significant others was affected negatively by their support needs, and therefore really welcomed being supported by professionals.

*"I was getting support through my family, and I would say my relationship with them is much better now I am not getting as much support from them. I now have my family back as a family, not as a support network. And it's nice actually to say "I come here, I get supported, I go home, I get my family."
(Participant service user focus group)*

4.64 Most participants agreed that it should be left up to the service user to decide if and to what extent significant others should be involved in their support. Staff mentioned that often tensions arise when service users and significant others have different views on the level of involvement and that these are difficult to negotiate. Confidentiality can also be an issue in involving significant others, as services have different guidelines on the sharing of personal information with third parties. Carers felt that, when service users reject involvement from

significant others, staff should keep the opportunity for their involvement open, rather than “closing that door forever” as the service user’s perspective can change over time.

Sense of humour

4.65 One competency that was often written on the post-its without forming part of the presentation or being present in the literature was “a sense of humour”. Service users described how laughter often helps them cope with difficult situations. It can lighten the mood, create a bond in groups, relax people and avoid too serious an atmosphere in which people solely focus on their problems.

“I find like talking about doom and gloom all the time it doesn’t help me, you know, you got to have a bit of laugh time.” (Participant service user focus group)

4.66 Sometimes, though, professionals do not seem to appreciate service users’ sense of humour. People talked of their laughter being labelled as “inappropriate” and staff not reacting to their jokes. The majority felt that mental health workers should be able to respond to and engage with humour.

4.67 Service users were also aware, however, of the dangerous side of humour, and felt that sometimes it can be inappropriate. When a worker initiates humour, it should be respectful and sensitive and never at someone’s expense. Ideally, they should gauge people’s moods and respond to these, because when there is too great a gap between how people are feeling and the mood the worker is projecting it is likely to make them feel worse.

4.68 In one focus group staff pointed out that they use a sense of humour within the team to process things that happen in their work. This generated a debate, with people acknowledging that the humour used is often quite dark and could be seen as disrespectful by service users. Some people felt that this meant that it could make other staff members feel uncomfortable as well, and that other ways of coping with difficult situations should be found.

Providing holistic support

4.69 Service users and carers felt there is generally an over-reliance on medication in the mental health system in Scotland. Medication is prescribed quite easily, and often for longer than expected, while other approaches and support that needs to be in place are neglected.

“Some psychiatrists just go like that [snaps his fingers]. You go into their office, “Have you been on these before, have you been on that before? Here, take it away.” That’s it, that’s you. “What’s going on here?” “Try them and come and see me in another six months time”.”(Participant service user focus group)

4.70 People acknowledged that medication definitely has its place and that sometimes it makes all the difference, but felt that their mental health is impacted by many factors, and that it is difficult to get support in dealing with some of these. One example is housing, with carers

pointing out that often people with mental health problems are housed in areas which are deemed unsuitable for others, like the elderly.

“I am not getting any help with my housing. My flat, its dampness, I’ve had it long enough and it’s driving my health down. I’ve been on the housing list for five years, I think I should be allocated a house by now.” (Participant service user focus group)

4.71 Another issue that participants felt needed more attention from mental health workers was helping service users to find meaningful activity. Having valuable work allows people to build up confidence, and gives them a sense of purpose and “something to get up for in the morning”. For some people having something to do during the day is beneficial in that it relieves loneliness and helps them to avoid focusing on mental health symptoms. Others said that their job provides them with “an anchor to normalness” and that it is a definite stepping stone on their journey to recovery.

4.72 People complained of poor attention to physical health in the mental health system, with physical conditions often being dismissed as psychiatric symptoms. One participant said it is important that people get more help with housework which they may not be able to keep up with when they are unwell. The resulting state of their home may in turn make them more unwell when support with this is unavailable.

4.73 Staff emphasised again how important medication often is in allowing people to cope with their mental health problem. It was said that they “couldn’t do half the work without somebody taking the medication first” (participant staff focus group). However, in most of the services that participated, staff described already working with a holistic approach and providing help with housing or exploring options for personal development. In one service, which was more specifically a work project, staff noted that not every service could be expected to “do it all”. However, in this project support with housing *is* sometimes provided, even though this is not part of its remit. Staff members felt that many service users live in impossible situations and that it is not always within a project’s power to change these given funding and structural limitations.

Alternative therapies

4.74 Participants talked at length about the helpfulness of alternative therapies and felt that these should be made much more available. Given the individual nature of the recovery process, different people need different kinds of help and several service users said that alternative therapies had formed a crucial part of their recovery process. However, most people do not have access to such therapies because they are seldom freely available and many people cannot afford to pay for them themselves.

4.75 Besides the problem of cost, carers and service users felt that they are often ill-informed about the possible benefits and availability of alternative therapies. One participant commented that, even though someone may not be able to access alternative therapies at a given time, they should still be told which treatments may be beneficial because their financial circumstances could change in the future.

4.76 Many participants had experience of using self-help techniques in dealing with their mental health and had mostly found these very useful. Relaxation and breathing techniques helped with anxiety and panic attacks, while using moodsheets and self-help books had also been beneficial. Most of these resources and techniques had been suggested by mental health staff, and service users felt that this was a very positive way of encouraging people in their journey of recovery.

Community

4.77 In the participants' discussions 'community' took up an important place in the promotion of recovery, both as a source of support and a goal of the recovery process. The term 'community' did take on a variety of meanings for the participants. As a source of support 'community' could mean becoming a member of a close group of people with experience of mental health problems. For a significant number of the service users who took part in a focus group this was an important means of regaining a sense of security, belonging and purpose.

“Well, I know the people in here are the same as I felt; I’ve got mental health problems and they are the same. And they are all my friends, we are like one big family. And that has been a big help to me. That’s what brought me on.” (Participant service user focus group)

4.78 For others, community involvement was about accessing a variety of resources offered in the community, ranging from support groups to taught classes and activity venues. These resources could be mental health specific but could also include resources available to the general public. Utilising general community resources, the carers emphasised, was a good way of overcoming stigma. Getting people in touch with community resources that were open to everybody, such as a stress awareness course, could mean a first step towards overcoming boundaries between the 'ill' and the 'normal'.

4.79 Being involved in the community, could further mean meeting new people, volunteering and community activism. Becoming fully reintegrated in the community was for many the main goal of the recovery journey.

“We’re getting people back into the community again. This is only a stepping stone. You come out of hospital, you come in here and then you’re back out again. Okay, it might take time, different people take different lengths of time, but that’s it, that’s the goal.” (Participants service user focus group)

Mental health workers need to recognise the importance of these different roles of the community and need to be sensitive to what might constitute the right level of community involvement for the individual person at a particular time. This means that mental health workers need to have an excellent knowledge of available community agencies, groups, and activities, and need to be able to develop people's interest in them and support them in getting involved. This is likely to be a slow and gradual process, which depends on service users' and mental health workers willingness to take risks. It is also important for mental health workers to understand that any person belongs to not just one but multiple communities at the same time. Each of these communities constitutes a potential source of support but regrettably also a source of stigma and barriers to recovery.

“I think it’s not necessarily community, but communities. Somebody might live in an area, so that will be their local community, then they might be a member of a minority, which is also a community, and whatever. There are hundreds of communities that people might be involved in and some of them may be more stigmatising of mental illness than others. It’s not just about what people want to do in a community, but about how open those communities are to them.” (Participant staff focus group)

Understanding and challenging stigma

4.80 Service users, carers and staff mentioned stigma as a major obstacle to recovery in Scotland, which makes understanding and challenging stigma an essential competency for mental health workers. Stigma was seen to permeate the mental health experience, from internalised stigma, to stigmatising behaviour by mental health workers and community-wide stigma.

4.81 Carers and staff talked about the difficulty service users and their significant others sometimes have in accepting the diagnosis. They felt this is at least partly due to the general public’s view of mental health problems, which people with no prior experience of mental illness often share.

“Schizo, psycho, all the films from days gone and the ‘see me’ campaign there need to be a lot more similar projects to that to change the public’s perception of what the different diagnoses are and then perhaps service users wouldn’t maybe be so upset about being diagnosed as a schizophrenic or whatever.” (Participant staff focus group)

4.82 Service users also talked of having to overcome their views of themselves as being defined by their diagnosis, with little else to offer or aim for. Many spoke of the guilt they feel about having mental health problems, having a negative outlook and claiming benefits. Mental health workers should be aware of internalised stigma and help the person to become aware of it and where possible challenge it.

4.83 Participants said that sometimes mental health workers reinforce stigma rather than counter it. In the focus groups several examples were given of stigmatising behaviour by staff, including speaking for service users when they are asked a question and making assumptions about people based solely on their diagnosis. Hospital practices were also said to perpetuate stigma. Participants questioned the need for mental health patients to line up for their medication while all other patients are given their drugs individually and the use of separate entrances in some hospitals. Staff, both within and outside of hospital, should reflect on their practice and whether it contains stigmatising elements. If so, they should aim to change their way of working and once more focus on and learn from the individual.

4.84 All participants acknowledged that the underlying problem is a society-wide stigma surrounding mental health problems. Service users talked of reactions of lack of interest, fear or disgust from people they had been friendly with previously when they told them their mental health diagnosis or admitted that they had spent time in hospital. Others mentioned their difficulties in finding employment with a disclosed mental health problem. These issues led

some service users to hide their diagnosis for up to twenty years, out of fear of people's and potential employers' reactions. Stigmatising attitudes were said to be compounded by the media, which often only mention mental health problems in connection to crimes and in other types of sensationalist reporting. Mental health workers should be aware of the pervasiveness of stigma surrounding mental health and be sensitive to the possible impact of this on mental health service users. They should help them cope with this and challenge stigma wherever possible.

Diagnosis

4.85 Because of the divergence in the literature about the importance of accepting one's diagnosis, participants' perspectives on this issue were sought. There were diverging views about the extent to which professionals are focused on the formulation of diagnoses. Some service users said that psychiatrists can be reluctant to "put a label" on people, which is not always in the interest of service users who are keen to find out more about the problems they are experiencing. Other participants said that professionals are frequently providing diagnoses that are based on insufficient knowledge of the person. They felt that there is still an over-use of labels and a desire to fit people into boxes.

4.86 Participants agreed, however, that receiving a diagnosis has drawbacks as well as benefits. Mental health workers need to support people in making sense of their diagnosis, and most importantly, need to help people understand that their diagnosis may cease to play a significant role in their recovery process.

"When I was first ill I thought it was important to get a diagnosis, but the longer this went on, I realised that it's not important. Maybe workers, when they first come in touch with somebody, they could maybe emphasise that the diagnosis isn't everything. Just explain that to people." (Participant service user focus group)

4.87 Participants identified a range of negative aspects of receiving a diagnosis, and felt that mental health workers should be aware of them. There is first of all the risk that receiving a diagnosis instils the expectation that a quick medical solution, for example, a "magical pill", can now be provided. In many cases, the experience of receiving a diagnosis can be traumatising due to the stigma attached to mental health problems, most notably schizophrenia. A problem is also that people are frequently given a number of different diagnoses and treatments until they receive the 'right' one. Consequently there is the danger that they may be given medication that causes unnecessary health impairments. There is furthermore the risk that people become too narrowly focused on gaining information about certain symptoms of their mental health problem but that they neglect other aspects of their mental health and quality of life.

4.88 Participants also perceived important benefits in receiving and engaging with a diagnosis. One important benefit is being able to access information and help specific to the diagnosis.

"The majority of people that I know say 'Gosh, now that I know I've got bipolar I can read all about bipolar, I can find out all the ins and outs what help is there for me'." (Participant service user focus group)

Once information has been accessed, the continuous process of coming to terms with one's diagnosis can lead to a better understanding of what one's mental health is like. Some participants said service users can only gain a sense of autonomy over their illness through a critical reflection on what does and does not match the diagnosis that they received. For others, receiving a diagnosis has alleviated feelings of guilt and distress and led to the acceptance of having an illness that is not going to go away. Once such an acceptance has taken place people can begin to adjust their expectations. Sometimes, receiving a diagnosis can mean that people can accept mental health workers' treatment suggestions, for example, to start taking medication, which can help them move to a level at which they can take first steps towards recovery.

4.89 More often, however, participants gave accounts of how the process of receiving and grappling with their diagnosis led to the realisation that due to everybody's personality and background being different there are limits to what a diagnosis can explain and that there are more important things to focus on, such as how they can move forward.

*"You begin to forget the diagnosis and learn to handle it. That's where recovery starts."
(Participant service user focus group)*

At the beginning of this process of working through one's diagnosis, mental health workers' responsibility should provide access to information about the diagnosis. Mental health workers should, however, place emphasis on the fact that accepting one's diagnosis as it is defined by professionals is not a necessary step in the recovery process. Acknowledging that you have a problem, was, however, considered by the majority of participants an important step forward. Mental health workers' should, furthermore, encourage service users to view the process of understanding their diagnosis as an opportunity to change part of their thinking. As one of the mental health workers who participated in this study pointed out, what is more important than the acceptance of a diagnosis is that the person learns to understand how the illness affects their ability to lead their life.

Peer support

4.90 Another divergence in the literature was the reliance on peer support in international recovery competency frameworks. In the focus groups people talked of two types of formal peer support. There was some mention of peer support workers, as they exist in America, where people who have coped with mental health problems are trained and paid to support others who are experiencing similar problems. This was seen as a potentially very valuable addition or alternative to professional support, but has not (yet) been developed in Scotland.

4.91 More was said about peer support groups, where all members have experience of mental health problems and support each other on an equal basis. These were seen as extremely helpful by all participants. Having other people with mental health problems to talk to helped members to feel less alone with their problems.

*"I think it's really crucial, 'cause you can't better life experience, everybody's journeys are different, 'cause everybody is individual but there are certain commonalities like isolation and fear and guilt and stigma."
(Participant service user focus group)*

It was felt that peers have a natural empathy and that having personal experience of mental health problems allows members to notice when others are having a difficult time. Overall, in the focus groups that were conducted in peer support groups, it was clear that membership of the group was a huge source of support for participants. Members also said that accessing peer services can be easier than accessing professional services, because knowing that others are struggling with the same issues takes away some of the trepidation and feelings of shame new members may be feeling. Often existing members support new members with coming to the group.

4.92 People felt that peer support groups form a good environment in which to build confidence and to take on responsibility and new roles, such as leading special interest groups or even classes. They allow members to draw upon each other's strengths and skills. Also, people reported using the groups to share information, which gives them more confidence and knowledge to challenge services. Carers noted that information from peers is often taken more seriously than that provided by professionals, and more likely to be acted upon.

4.93 There was some sense that accessing a peer support group may be difficult for some people, as it implies admitting to yourself that you have a mental health problem. However, others said that this can be the start of the journey to recovery and help eliminate preconceived ideas that people may have about other service users. It was seen as important that people find the right group for them and that it would therefore be helpful if there was a greater variety of groups available.

“Sometimes you know moaning and groaning all the time isn't a help, but groups need to sometimes maybe do other things as well as support one another with mental health problems. So I think it's got to be the right group.” (Participant service user focus group)

4.94 Carers especially felt that peer groups organised around specific interests are needed. There are many people who may not necessarily want to focus on their mental health, but would like to find others who share their passion for a certain hobby or interest and also have an understanding of mental health issues.

4.95 It became apparent in the focus groups that members of peer support groups sometimes support each other with quite serious issues and that this can lead to problems because they usually do not have access to the support and supervision necessary to cope with this. For staff at these services confidentiality is an issue, as they are not able to discuss someone's background with the peer supporter, thereby making it difficult to offer help. Also, some groups are run by volunteers who felt that given their input they should become paid members of staff, which would provide them with support structures.

4.96 Staff in one focus group discussed the possibility of having peer support workers on the team, which led to some disagreement. One member of staff commented that it would be difficult for the other staff to always be sensitive to the peer support workers' point of view.

“Nobody likes to feel like here is somebody watching you judging your work, we all make mistakes we all do daft things nobody is perfect in our jobs and it would be a terrible

feeling to have somebody be critical of you, when you are not allowed to be human yourselves. I think that would be worrying.” (Participant staff focus group)

Others felt that this sensitivity should be present in their work anyway, especially as existing mental health workers may very well have an undisclosed background of mental health problems.

Obstacles

Time constraints and staff motivation

4.97 One major obstacle to a recovery-oriented way of working that came up repeatedly in the focus groups was a lack of time and resources. Often, there are long waiting times for crucial services and people felt that not getting timely help hindered their recovery. But even once services are accessed people felt that staff still do not have enough time to spend with them. Participants noted that the stress staff are put under can make them less motivated to work in a person-centred way.

“I mean, nurses are working very hard. If you spend your whole day policing people who gave you the worst side of their tongue, were ready to hit you and be violent towards you, it is very hard to go into your work the next day motivated, open, touchy feely and working towards recovery, but people like us, that’s what we need, you know.” (Participant service user focus group)

4.98 One group especially noted that in the hospital in their area certain groups of patients, notably those with addiction issues, take up a lot of staff time, and felt that there should be separate places for such patients so that others can get the attention and care that they need. Other contributing factors to the lack of staff time are the perceived amount of paperwork that workers have to deal with, low staffing levels and a lack of definition of professional’s roles, which means that highly trained people may spend valuable time completing basic tasks; the feeling was that joint working should be improved in order to avoid this. A further obstacle to recovery-oriented practice is that staff are not given enough time away from their day-to-day job to attend training events that introduce new ways of working.

4.99 One solution that was proposed to overcome the problem of staff becoming tired and frustrated in a particular service was to rotate them between services, so that they come into contact with different working cultures and have a chance to start afresh.

Inconsistencies in service development

4.100 Participants in the staff focus groups recounted confusing experiences with policy directions in mental health in the past. Some said they feel somewhat reluctant to embrace the recovery approach, because the drive for this approach may only be temporary, as has been the case with previous initiatives.

“I would like to make a point about staff’s attitude towards recovery. You do come across different models of care being proposed, and it’s difficult to say which one is the best one, the right one, and actually, which one we’re sticking with this month, because it does change.” (Participant staff focus group)

Other staff members noted that previous pilot projects that facilitated recovery often did not receive further funding, even when they had been found to be very effective.

Service user motivation

4.101 There was some sense in the focus groups that one obstacle to a recovery approach may be a lack of motivation on the part of service users. Carers mentioned that some people may not be willing to engage with recovery because they have not yet accepted that there is anything to recover from. Others may have found a safe place that they do not want to move on from, even though they may find their lives less than meaningful.

“I think it is difficult with some of the service users how far they want to engage, and perhaps they don’t want to engage. You know, it is easier being in your own world, and similarly, people saying rationally “it helps if you interact with others” that is all very well, but if the resistance comes from the individual and their input is crucial in their recovery, then how do you get around that? It’s not straightforward, not at all, recovery.” (Participant carer focus group)

4.102 There was some consensus amongst participants that it may be hardest to recover for the people who have had years of engagement with the mental health system and are used to a different type of care and support. Also, some people may have become dependent on services or institutionalised. One participant commented that it should not be a case of staff going along to recovery training and then the next day pushing this approach onto their service users. Instead workers should be sensitive and involve service users in decision making, including which approach they are the most comfortable with. Also, recovery can take a very long time. This means that even though it may seem that someone has no desire to recover and is not able to make changes, it is still necessary to work with them in a way that is compatible with the recovery approach.

Welfare system

4.102 Staff participants felt that the biggest obstacle beyond the mental health system to recovery is the welfare system. It is deficit-focused in that benefits are only available when someone has been diagnosed and reports all the difficulties that result from this diagnosis. Also, being on benefits can prevent people from moving forward. Mental health workers said that often for service users moving towards recovery means getting a job, but that because doing so would jeopardise their financial situation, and thereby their mental health, they are not able to do this.

“It does threaten your financial stability, if I am recovering, if I am getting better and having a decent quality of life somebody is going to come and take away my financial stability and it’s all going to fall apart. That’s a very very big fear for people, because often people have taken years to actually get the right benefits in place and have the idea that if you recover somebody may take them away.” (Participant staff focus group)

4.103 Staff members also said that this fear is realistic in that it will be very difficult for most service users to find a job that compensates for losing their benefits. Also, the benefits system makes it very difficult for people to dip in and out of work as their mental health allows, or to find part-time work to suit their needs.

Towards a recovery competencies framework for Scotland

Relevance

4.104 None of the three mental health teams felt the core recovery competencies outlined in the literature review presented an entirely new approach to working with service users. The mental health workers identified considerable overlaps between the eight principles and their work. One group of workers noted that it may not be appropriate to expect every service to practise all of the principles. Particularly in relation to the provision of holistic support and advocacy it may be more fitting to refer people to specialised services in the community. This view was shared by some of the service users, who felt that given the time constraints under which mental health professionals are working, they would prefer to receive advice and support that was directly related to the professional’s area of specialisation, for example cognitive therapy, rather than having their CPN or psychiatrist attend to issues of housing or employment.

4.105 In general, mental health workers confirmed that the recovery approach is compatible with the service they provide. The definition of recovery as ‘living well, whatever that means to you, in the presence or absence of symptoms’ was welcomed by the mental health workers who were aware that people struggle with the concept of illness in mental health and are reluctant to accept others’ definitions of their wellness.

Implementation

4.106 Mental health workers, service users, and carers agreed that support for the recovery approach needs to come from the Scottish Executive, with commitment from managers at all levels to make changes happen. For the shift towards recovery-oriented care to be successful changes should be implemented nation-wide and across services, rather than only involve part of the mental health workforce. Although participants felt that the implementation needs to be driven from ‘the top’, they highlighted the need for ongoing consultation and collaboration with people at ground level. It was seen to be important that mental health workers’ existing ways of working were respected and acknowledged, since the process would otherwise be alienating and counterproductive.

4.107 Additional training for mental health workers constitutes one pathway for bringing about change, but participants also noted that training does not always change practice. Some service users suggested the way forward is to train people through placements in service user projects. Presently placements in service user led projects are taken up by people who already share an interest in recovery-oriented ways of working, but there is minimal uptake from medical professionals. Mental health workers favoured training as a team, in combination with joint training together with a range of people from different services. It was important to them that any training course avoids being perceived as promoting an anti-medical stance. Currently many training courses in mental health are available on a voluntary basis, and there may need to be a “push” from the top to increase training uptake. Staff rotation was suggested to be a good means of ensuring the continued exchange of good practice and would also prevent burn-out.

4.108 Implementation also needs to take account of a number of factors specific to the Scottish context. Participants repeatedly stressed that in Scotland people were still suffering from a lack of self-esteem. Scots, they felt, are not good at speaking up for themselves and would feel uncomfortable with demanding choices and rights. In comparison to other countries, Scotland was also perceived to be particularly averse to risk taking. Finally, it was noted that due to the unfamiliarity of the concept and Scottish people being more inclined to keep things to themselves, there could be a reluctance to engage in peer support.

CHAPTER FIVE FINDINGS INTERVIEWS

Introduction

5.1 To assess how far current curricula focus on recovery and what possibilities there are for implementing a recovery focus in the future, nine interviews were conducted with people in key positions in the training of mental health workers. A senior nurse involved in the implementation of the Tidal Model in Glasgow was also interviewed to reveal lessons learned from that process. In total, ten interviews were conducted, some with two participants at the same time. Considering the diversity of training courses for different mental health related professions, it was only possible to interview a very small number of people (sometimes only one) within each discipline. The findings outlined below provide an overview of current training, the recovery orientation of this training and obstacles to the implementation of a recovery competencies framework within each discipline. Because these findings are based on the opinions of a small number of educators in the field and training varies between regions and training institutions, they should not be read as factual descriptions of the current state of mental health training in Scotland as a whole. The findings provide a snapshot of possible opportunities and obstacles in mental health training and thus offer a starting point for a reflection on avenues for training development. While participants identified a range of different opportunities, these tended to overlap for the different professions, which is why they are discussed at the end of the chapter. The obstacles identified were usually more specific to the discipline under discussion and are therefore outlined in each section. In general, however, the tone of the interviews was positive and most of the people interviewed were optimistic about the possibility of implementing a recovery approach in Scotland.

Occupational therapy

5.2 Two educators in occupational therapy at a Scottish university were interviewed together.

Current training

5.3 Occupational therapy is taught in universities as an undergraduate degree. In the university where the interviewees worked, the course takes four years, with six placement periods. Mental health specific modules are taught in the first and second year, with the first module focusing on moderate mental health problems. The module in second year looks more in-depth at issues such as legislation and familiarises students with illnesses such as schizophrenia. Where possible, two of the students' six placements are arranged to take place in a mental health setting; one in an acute or hospital setting and one in a community or long-term service. Placements take place all over Scotland (and sometimes beyond) so that students have an opportunity to come into contact with different levels of deprivation and ways of working.

Recovery

5.4 For the past four to five years, the underlying focus of the degree course has been on health and well-being. As described by the interviewees it fits well with the recovery approach and is taught in such a way as to minimise stigma. Throughout the degree students are encouraged to be alert to the possible presence of mental health problems amongst their client group, especially given the impact physical problems may have on a person's well-being.

“Although the students are taught in modules about mental health we are really trying very hard to get them to think about that through all the different modules. That mental health doesn't just happen in isolation, so it's not just in psychiatric hospitals, that you may find it in physical settings in community settings, so really trying to kind of break down, well I suppose break down the walls of the boxes that we are teaching here, get students to think across.” (Occupational therapy educator)

The course coordinators aim to normalise mental health problems by asking students to reflect on their own experience of mental health and encouraging them to see mental health as a continuum.

5.5 A key message is that the impact a (mental) illness may have on someone's life is very individual and that therefore a person's views, experiences and goals have to determine their treatment. The aim is to work in cooperation with service users and to respect their choices. The use of community settings is a central component of the course and gives students the opportunity to reflect on the impact of different environments on both themselves, in terms of their role and reactions, and on service users. In addition, students build up knowledge of community resources and ways of facilitating access to them by visiting voluntary agencies.

5.6 There has been some service user involvement in the course: over the past years the National Schizophrenia Fellowship have come in to teach about their organisation, with a service user telling students about their experiences of symptoms, such as delusions or lack of motivation, as well as their experience of services.

Obstacles

5.7 Service delivery varies between different parts of Scotland, with some areas being largely reliant on hospital-based services, whereas in others the focus is on community care. This, combined with the pressure on services generally and different approaches to mental health, means that sometimes students on placement feel that they cannot put their training fully into practice. Generally, other professions may be more prescriptive in their dealings with service users while the medical model can inhibit therapeutic relationships based on an equal footing and limit the extent to which students can practice in a person-centred way.

5.8 Students themselves sometimes find it hard to respect patients' choices, including the way in which they live and whether they choose to turn up for treatment or not. They are not always confident enough to challenge other professionals or to defend their own ways of working.

Psychiatry

5.9 Two psychiatrists who work in rehabilitation and have designed a module for the local training course for junior psychiatrists were interviewed together.

Current training

5.10 After finishing their medical degree and having spent two foundation years becoming acquainted with different medical disciplines, aspiring psychiatrists spend several years in further “apprenticeship” training, with three hours of teaching a week and the rest of their time spent working as a Senior House Officer in a team: seeing patients, prescribing, and working with a senior doctor who supervises their practice. The formal structured learning part of the training scheme is mostly focused on the “nuts and bolts” of the trade, i.e. it is about “learning about medicine”.

Recovery

5.11 The interviewees have recently devised a bit of recovery-focused training for SHOs, within the rehabilitation module, which is taught over two days and will run for the first time next year. The second day will have a recovery focus, with a service user telling their story, Simon Bradstreet from the SRN giving an introduction to recovery and one of the interviewees giving a lecture on the history of psychiatry, needs assessment and different models. The day will be completed by a lecture on commissioning community services and social models of illness and care. While the interviewees felt that recovery is the basis for all psychiatric work, with its aim of getting people back into their lives, they acknowledged that whether SHOs come into contact with the recovery approach in their work depends on their team and specialisation. For example, rehabilitation teams are less focused on medication issues and are more likely to work in a recovery-oriented way, while some psychiatrists may practise with quite a pessimistic view of recovery, which therefore can become the dominant approach in some teams. Overall, the interviewees felt that psychiatrists could complete their training and not come across the recovery approach.

5.12 Also, working with the aim of recovery does not mean that psychiatrists always work in ways that have been found to facilitate recovery. The interviewees felt that there needs to be a shift towards asking patients what they want (and trying to reach a compromise when this runs counter to what the psychiatrist thinks is necessary), involving significant others more successfully and taking the whole person into account.

“I think contextual stuff is not done nearly enough. That this isn’t a woman with mania, she’s a wife and a mother, she’s a grandmother and it’s important for her to fulfil those roles and how can we help her do this. That gets lost, you’re just thinking of an episode “She’s manic, let’s get her better”, but the rest of the stuff just gets kind of forgotten about.” (Consultant rehabilitation psychiatrist)

Obstacles

5.13 Perhaps the main obstacle to implementing the recovery approach in psychiatry training and practice is a lack of time. Given the amount of material that students need to be taught to satisfy the curricular requirements set by the Royal College of Psychiatrists, there is very little time to introduce the recovery approach. In practice, there is pressure on psychiatrists to handle large case loads, which sometimes mean they have little time to speak to patients, to be reflective about their practice or to seek other's opinions.

5.14 Another obstacle is conflict in their relationships with patients. Psychiatrists use the Mental Health Act to impose compulsory measures, which sometimes alienates people, after which it can take a lot of time and effort to re-establish a recovery-focused relationship. Also, the nature of mental health problems can make people oppose the suggestions made by psychiatrists, with lack of insight often meaning that they do not want to accept help.

5.15 Psychiatrists do not always have the power to change the physical setting within which they work, such as the arrangement of consultancy rooms, which can reinforce power dynamics. Equally, they are often unable to offer people therapies that would be helpful in their recovery process, such as psychological therapy.

5.16 A last obstacle is the perception of psychiatrists by other stakeholders in the recovery movement.

“I think, the other problem about it is, if you go to recovery events and you are maybe the only psychiatrist, or there is a couple of you, you do get a hard time. People spend the whole time sometimes criticising psychiatry.” (Consultant rehabilitation psychiatrist)

The interviewees felt that the recovery movement had to some extent been hijacked by the anti-psychiatry movement, and that this, combined with the lack of recognition that psychiatrists get for the recovery-oriented work they are already doing, can alienate psychiatrists. As it is, interest levels in recovery seminars and events are low.

Social work

5.17 Two people who are updating the curriculum for Mental Health Officers were interviewed, as well as one educator involved in providing awareness training in the new Mental Health Act.

Current training

5.18 Social workers are trained in universities, by doing an honours degree. The content of the courses varies across different universities, as evidenced by variation in the interviewees' accounts of the amount of general mental health awareness training delivered at pre-registration level. One interviewee said that this was largely absent on their course, while another, who used to teach at a university said that there *was* awareness training, with a focus on trigger points and

what support is available. Roughly half of the degree course is spent on placements. After students graduate, they move into one of three areas: Adult Care, which includes mental health, Children and Families or Criminal Justice, and receive further training relevant to their area. The quality and quantity of this training very much depends on the local authority in which they work and its training section.

5.19 Once social workers have a minimum of two years' (and usually some mental health related) experience they can train, if selected, to become a Mental Health Officer. MHOs are social workers who play an instrumental part in assessing and supporting or making applications to ensure that those meeting certain criteria receive compulsory care and treatment in hospitals or the community. People on compulsory treatment orders, or on certain orders relating to mentally disordered offenders, are given a designated MHO, who will support them in a range of ways. The Scottish Ministers issue directions on appointment and maintenance of appointment of MHOs. This, in conjunction with clauses of the legislation itself, sets basic conditions on MHO training. However, the existence of over-arching principles enshrined in the Mental Health Act ensures that practice is only lawful if it is in keeping with human rights and that the values and ethical practice that flow from this are also reflected in the training.

5.20 Because generic social work staff were found to have very little knowledge of the previous Mental Health Act, training has been provided in the new Mental Health Act to many social workers, especially those in community care teams. Training has been available to generic staff in some areas, but has had to compete with many other demands on social workers' time.

Recovery

5.21 There was disagreement amongst the interviewees as to how closely the value base of social work (training) matches that of the recovery movement. One interviewee said that he himself did ascribe to principles closely related to recovery, but that he felt it was difficult to impose this on other practitioners, although social work has historically been based on the social model. Another interviewee said that, while the training and practice of social workers may not explicitly be about recovery, the principles underlying the recovery movement are very much "the bread and butter" of social work teaching and social work.

5.22 In the first years of one undergraduate degree students take modules in the social sciences and in values and ethics, so that a critical understanding and an ability to be reflective are nurtured. These qualities are then assessed in placements and in the university setting, with trainees being asked to demonstrate and reflect on how they work with values and principles in practice.

5.23 Other elements that are addressed in training are: working alongside the service user, how to manage risk, how people make decisions and their right to make decisions, issues around power and authority, encouraging family support, support networks and the balance between collaboration in decision making and protection. While the term recovery itself is becoming more common, it is not yet widely used in social work, and interviewees felt that making it more explicit could be useful.

“The usefulness of the idea is that it sums up a whole range of things into one sort of bag. And I am sure they could do with, if you asked 200 students what recovery was, maybe a quarter of them might know vaguely, so I think we could do with summing that up a bit more.” (MHO advisor)

5.24 Since 2004 it has been a requirement of the social work qualification that service users are involved in different levels of the training. Service users are now involved in the design of courses, the selection of students, and give feedback to students on their placements. In some universities service users also come in to lead seminar discussion on, for example, the impact of services. While this was perceived by the interviewees as a positive development, they felt that, to avoid exploiting people, appropriate training, support and remuneration should be put in place. There was also a concern that the involvement of service users in recruitment for employment could be less than meaningful, especially when they are not aware of the demands of legislation, which means that the final decision will always be made by the employer.

Obstacles

5.25 While social work aims for a preventative way of working, lack of time can mean that there is a shift towards its practice being more crisis led, and therefore less compatible with recovery. This often happens when teams are short-staffed and therefore do not have the time to build relationships and to get a sense of people’s wishes and needs.

5.26 One interviewee stated that some social workers seem to have lost their humanity in working with service users. He asserted that, as humanity is the key to working with people, this is a problem that needs addressing. To make a shift towards the recovery approach possible the generally poor supervision in social work needs to be improved; without proper supervision it is difficult for staff to reflect on their practice and to remain motivated.

5.27 Also, social work needs to give responsibility back to people; to find the balance between caring for service users when they are unable to take control themselves and giving them responsibility for their lives so that they can grow. At the moment responsibility is often not given in order to avoid risks.

5.28 All in all, there was a sense that, while recovery principles are embedded in a lot of the social work training, once students move into employment some of these may be lost.

“Social work training works in an ideal world and I think when people go out there in the real world and match those ideals with reality, some of the more idealistic edges become knocked off that.” (MHO advisor)

5.29 One interviewee felt that there was a risk that adopting a recovery approach in social work services could be used by local authorities as a way to rationalise a reduction or time-limit on services. By taking a very simplistic view of recovery they could reason that mental health specific services are contributing to social exclusion and dependency and should therefore be reduced to the absolute minimum. However, for some very vulnerable people even accessing these services can be a huge step forward and having a variety of flexible services is crucial.

Clinical Psychology

5.30 One clinical psychologist with a key role in one Doctorate of Clinical Psychology course was interviewed.

Current training

5.31 Becoming a Chartered Clinical Psychologist requires the completion of a full time three year post-graduate doctoral training programme. Entry requirements are a psychology degree, Graduate Basis for Registration with the British Psychological Society and usually one or two years experience either as an assistant psychologist or a research assistant. Over the three years of training, which consist of academic course work, research work, and clinical placements (selected to cover a wide range of training opportunities and geographical areas), trainees work with a broad range of clients in a broad range of settings. During training they develop competencies in psychological assessment, formulation, intervention, evaluation and research. The training aims to produce clinical psychologists who are committed to reducing psychological distress and enhancing and promoting psychological well-being through the systematic application of knowledge derived from psychological theory and evidence. It is intended to provide trainees with skills that enable them to work as client-focused scientist practitioners and to develop their work through both ongoing critical self-reflection and research.

Recovery

5.32 The interviewee felt that the recovery approach was integral to the existing training. Throughout the training a reflection on values based practice is reinforced. Principles embedded in the training are a focus on resilience and strength, conceptualising service users' goals in terms of quality of life and wellbeing as defined by the individual person and recognising service users' values and cultural context.

“But also there is a model of reflective practice. And that is based on developing an individualised formulation or understanding of that person taking into account their values, cultural values, community values, the context, and major problems that they have, and what they want out of therapy.” (Clinical psychology educator)

5.33 The range of placements trainees undergo necessitates an understanding of the wider context within which care is delivered. Trainees are required to demonstrate their awareness of social exclusion and discrimination and the implications this has for their interactions with service users. Although the interviewee was hesitant to generalise across the clinical psychology field, he considered “working collaboratively and as partners with people” a principle that was shared by all clinical psychologists. Although there may not be a module on the recovery movement per se, service users are invited to give talks about their experiences during some of the training modules (e.g. experiences of psychosis).

Obstacles

5.34 Changes in the training of clinical psychologists are confined by the requirements of the professional bodies that have accredited the course on specific competencies. It was the personal opinion of the interviewee that a focus on changing training was less useful for driving change than a focus on systemic and organisational issues. The training of clinical psychologists, he felt, was, in many ways, already oriented to recovery. Clinical psychologists are being trained to work collaboratively with service users but this requires that there are structures in place that support such work. The interviewee felt that a major obstacle to developing services in line with the recovery approach was the lack of involvement of service users at all levels of service provision in Scotland.

“The way in which services are organised doesn’t place the user at a very high level. I don’t see many services in Scotland where service users are, for example, involved in designing the service, where they are involved in interviewing staff, where they are involved in evaluating the service.” (Clinical psychology educator)

5.35 At the moment, an obstacle to the full facilitation of collaborative working is the lack of standards of good practice for incorporating users. In order to involve users meaningfully there needs to be an investment in supporting users in developing skills and providing them with reference groups and peer support.

5.36 Constraints due to service design also constitute an obstacle to the provision of holistic services and supports. It was the interviewee’s opinion that holistic care could not be provided by one profession but required the commitment of a multi-disciplinary team. When a service as a whole has an orientation to holistic support clinical psychologists are able to support it, but at present not all services organise in a way that allows such an orientation.

5.37 Finally an obstacle, on a training level, would be that the top down implementation of a recovery competencies framework may be perceived as too prescriptive and ‘just all words’. If there was, on the other hand, clear leadership for putting resources into engaging users in design, research, running and evaluation of services then training would inevitably orient towards recovery.

Nursing

5.38 One interview with a mental health nursing educator with experience of developing and delivering the pre registration programs was conducted.

Current training

5.39 Nine universities across Scotland provide the three-year pre-registration programs that leads to registration as a mental health nurse. In addition there is ongoing training for nurses who are already registered. The first year of pre-registration training consists of a common foundation programme, which all students entering into nursing take together. This is followed by two years

of specialisation. Pre registration nursing courses in the UK are regulated by the Nursing and Midwifery Council (NMC). Higher education institutions have some flexibility in the way the course is structured but 50% of the program is theory and 50% of it is practice placements interspersed throughout the three years of training.

Recovery

5.40 In the opinion of the interviewee the amount of recovery focused training that nurses receive will vary across higher education institutions. The interviewee suspected that on the whole there was little focus on recovery in the programs since the recovery agenda is still new in Scotland and has not been widely embraced by service providers. Therefore it is also unlikely that trainee nurses will gain experience of a recovery approach to practice through the placements they undergo in NHS services. One outcome of the recent Mental Health Nursing Review is that a new Scottish framework for pre-registration education will be developed. Envisaged changes will involve a shift towards values-based, principles-based and rights-based practice. Additionally there will be an assessment of what training and education qualified staff need in order to support recovery-based approaches in practice. The remit of nurses in the recovery process is understood to be about working in ways that facilitate recovery rather than inhibit it. However, care needs to be taken that recovery does not become ‘professionalised’ and training needs to emphasise reflection on what role nurses play in recovery.

“Recovery is not something that mental health nurses do to people and it’s not a list of interventions that mental health nurses do to people to make people recover and I think there’s a real risk in viewing it in that sort of way, because what we are talking about is something that belongs to the person and is their journey.” (Mental health nursing educator)

5.41 Although nurses will only play a small part in recovery because mental health services as a whole have just a small role to play in the process, they need to be aware that their part can be important, for example, in preventing dependency on mental health services.

Obstacles

5.42 A significant obstacle to both training and practice constitutes the continued dominance of the medical model in the health field, since it limits how mental health workers think about people and their experiences. A further obstacle is the belief that recovery training is about the teaching of skills and interventions. Recovery training needs to be about attitudes, ways of working with people and having opportunities to step back from practice in order to continuously reflect upon it. The challenge remains how to articulate competencies in training that are about human ways of working and reacting to people. Beyond this there is the problem of bridging the gap between training and practice.

“We can teach them what we want in the pre-registration program, but if you don’t practice it then it will get lost. Or if the practice is the opposite of what is being taught, it creates a huge load of dissonance for students.” (Mental health nursing educator)

5.43 There are also a number of obstacles on a system level. First of all nurses' ability to change their practice is constrained by the service system structure within which they work. This means that time needs to be allocated to build infrastructures that support people in working in new ways.

Vocational qualifications in social care

5.44 Three interviews were conducted with educators in the field of vocational college qualifications: one interview with an educator in charge of the coordination of the Scottish Qualifications Association's (SQA) Social Care program delivered at one college, one interview with two educators delivering the City and Guilds Level 3 Certificate in Community Mental Health Care, and one interview with an educator in an advisory role for City and Guilds courses in Scotland. Feedback was also sought from students who are currently enrolled in the Level 3 Certificate in Community Mental Health Care.

Current training

SQA Qualifications

5.45 Currently vocational qualifications with relevance to mental health care can be obtained by taking courses in Health and Social Care taught at Scottish colleges. They range from very basic level courses for people with no qualifications to courses for managers in social services and are not specific to any client group. Social Care NQ, SVQ, and HNC courses are taught in the SQA regulated format across Scottish colleges, with colleges retaining some flexibility with regard to how they teach the lower level courses. This means that individual colleges can make SQA mental health modules mandatory for the lower level courses, for example for the NQ in Social Care, but that mental health modules remain optional at HNC level.

City & Guilds Qualification

5.46 The Level 3 Certificate in Community Mental Health Care has been developed in collaboration with the Mental Health Foundation and is aimed at staff, volunteers, service users, and carers who do not have professional qualifications but have experience of care in settings ranging from residential care to supported housing and general community care. In Scotland the Level 3 Certificate may be taken alongside SVQ modules or independently, and is taught part-time on a day release basis. It consists of eight units focusing on: descriptions of different mental health problems, an awareness of discrimination, promoting mental health, legislation and policies, care planning, communication and relationships, promoting independence, supporting individuals with relationships, enabling people to manage change, team and joint working, working with carers and support groups.

Recovery

SQA Qualifications

5.47 SQA mental health modules were designed before a recovery agenda was introduced in Scotland. Currently, recovery is not an element of the units taught, unless individual tutors choose to include additional material on recovery. The interviewee felt that at present it was possible that students underwent Social Care qualifications without coming across the term recovery. Some of the course components nevertheless are compatible with the recovery approach. There is a particular focus on the effects of stigma, people's multiple support needs, and different ways in which support can be provided. Overall the mental health modules are orienting students to the possibility of leading a meaningful life after a diagnosis of mental illness. The interviewee felt, however, that this aspect of care could be made more explicit if there was an overarching coherent recovery message in social care teaching.

“We are not telling students that people get ill and that’s them. We don’t do that. But now that we know about the recovery network programme, the tutors will start to talk about recovery; will start to use that language.” (College educator, social care)

5.48 It was the interviewee's opinion that service user involvement in teaching and training at college level is virtually absent at present. However, some tutors have in the past invited service users to talk to students about their experiences of mental illness and students experienced this as a very powerful way of teaching.

City & Guilds Qualifications

5.49 The primary aim of the Level 3 certificate is to enable students to reflect on their practice and to give them the tools to identify how they could do things differently. The course is underpinned by a holistic and person-centred model of care, which means that students are taught to consider all aspects of a person's needs, to value their experience and opinions, and let these determine how care is provided. Recovery, as a label, distinct approach, or movement, is not part of current teaching but both interviewees felt that it is very much embedded in all components of the course. Students learn about recovery when they familiarise themselves with different models of mental health at the beginning of the course. The course defines social care workers' role as assisting service users in challenging a debilitating illness view of mental health problems and to assist them in creating a new life for themselves. There is continuous emphasis on erecting an equal partnership between worker and service user. Students learn to analyse interactions in terms of how control has been shared in a situation or how certain ways of communicating with a person can be disempowering.

5.50 The interviewees also pointed out that having service users and carers studying on the course alongside mental health workers has been extremely beneficial. The way in which students are taught mirrors how recovery-oriented practice should be conducted. The course is student led, it builds on students' experiences, learning takes place through group work, and students learn to challenge each other in an open but respectful manner. The course aims to

empower students by highlighting the contribution they can make to the service and gives them the confidence to challenge the view that mental health professionals ‘know best’.

5.51 The students felt that the Level 3 course was remarkable for several reasons. First of all, having people with different backgrounds and from different kinds of services (e.g. the service areas included homelessness, criminal justice, disability, counselling) on the course was a significant advantage. They developed their knowledge of mental health issues, community resources, and examples of good practice by drawing on each others’ work and life experience. In contrast to other courses, where some of them had experienced a clear divide between students and lecturers, they felt that their experience and opinions were appreciated. Even the more complex aspects of the course material, like the Mental Health Act, were made accessible by linking it to their practice. They felt the course was more challenging than other courses in the same area because it forced them to rethink their relationships to service users. The course provided them with an understanding of a range of different aspects relating to mental health, including medical knowledge, which the students found extremely useful.

Obstacles

SQA Qualifications

5.52 The interviewee felt that both the Scottish Qualifications Authority and teaching staff at the college would be open to a review of the current modules. However, the SQA and Scottish colleges need to gain a greater awareness that an update of the current mental health modules is necessary and that these modules need to become core requirements for social care courses. The interviewee also thought it crucial to increase the mental health knowledge base of all college staff, in order to overcome negative attitudes and a feeling that they are not qualified to help.

City and Guilds

5.53 The main obstacle to the wider implementation of the Level 3 Certificate is the fact that currently only SQA qualifications can be accredited under the Scottish Credit Qualifications Framework (SCQF). Only qualifications recognised under the SCQF count towards a registration with the Scottish Social Services Council. Currently, therefore, employers do not view the Level 3 Certificate as a key piece of training. When the Level 3 Certificate was launched in Scotland, the Scottish Social Services Council also set the target of having sixty percent of the workforce trained at SVQ level three. An unintended side effect of this target was a narrowing of people’s focus and pressure on employers to meet this target.

“The problem is everybody then aspires to the minimum instead of looking at the different ways of arriving at that objective of a competent workforce.” (City and Guilds advisor)

With employers not receiving funding to get their employees trained on the Level 3 Certificate and with new credit frameworks taking a long time to be developed, recruitment for the City and Guilds course has at times been difficult.

Tidal Model

5.54 A senior nurse who was involved in the implementation of the Tidal Model in Glasgow was interviewed. Some of the main lessons from that implementation are outlined below.

5.55 Prior to the implementation of the Tidal Model, key nursing staff, including managers, were given two days of training, with all other staff on the pilot wards receiving one day of training. The interviewee stressed the importance of post-training supervision and the ongoing support from trainers and practice development staff in keeping staff engaged with the Model and critically reflecting on their practice. Existing supervision structures and managerial meetings were used to discuss issues related to the Tidal Model implementation. The pilot wards also received advice from a Tidal Model Steering Group with representatives from the three hospital sites in which the Model was implemented.

5.56 A review of all care plans and documentation and assessment models was carried out to bring them in line with the Tidal Model. It was important, however, not to demand that all practice was in line with the Tidal Model from a certain date, but to ask teams to try it out for a while and then to feed back what worked well for them and what they found difficult, so that possible obstacles could be identified and solutions found. Care was taken to emphasise the good work that was already being done on the wards and not to present the model as a total departure from existing practice.

“There were lots of good things going on and it was important for staff to get the message that we were acknowledging the good work that they had done and were looking for opportunities to integrate that good work into the Model, instead of throwing it all out and telling them it all had to change.” (Senior Nurse, Greater Glasgow and Clyde Mental Health Partnership)

5.57 The implementation of the Tidal Model did not necessitate the employment of additional staff, except to enable the teams to go on training. The extra time that nurses spent one-to-one with patients was off-set by the reduction in critical incidents, complaints and the need for clinical observation on the wards. Because of the review of existing procedures, resources are being used more efficiently. The implementation of additional support and improved team working contributed to nurses having more time to engage with service users.

5.58 Despite these indicators of success, the interviewee acknowledged that those presently administering and receiving training in the Tidal Model are only at the beginning of their journey towards a recovery based culture of mental health care. Such a shift requires time and the joint effort of mental health teams, service users, senior managers and the Health Boards. Promoters of the Tidal Model are, moreover, keen to stress that they do not view the Model as the only possible way forward. Any approach to system change would, however, need to begin with aligning policies, clinical guidelines and protocols with service users rights and recovery values. A key objective in this process is to get people to understand the principles of recovery and to critically review their practice according to these.

“We need to look at our current approaches to care, we need to understand and define what makes a good recovery approach to care and what we are currently doing, and

benchmarking ourselves against that to see what our strength and weaknesses are, we need to be doing that across the country.” (Senior Nurse, Greater Glasgow and Clyde Mental Health Partnership)

Opportunities and Pathways for Change

5.59 The interviewees identified a range of developments in Scotland that create opportunities for the implementation of a recovery approach to training and practice.

Legal and structural developments in Scotland

5.60 The majority of the interviewees considered the new Mental Health Act to be a significant driver of change. First and foremost, the Act’s underlying principles lay the foundation for a reflection on ways of working that safeguard service users’ rights. By requiring the support of Mental Health Officers at tribunals, it is ensured that both social and medical perspectives are taken into account. The psychiatrists interviewed stated that the tribunals required by the Act give them the opportunity, in a conflict situation with their patients, to refer the decision to others and therefore to not be seen to make decisions directly against patient’s wishes. Other interviewees felt that the Act provides important “check-points” for seeking a balance between rights, risk and safety.

5.61 Scotland’s move towards the integration of health and related care means that people increasingly work in multi-disciplinary teams. A number of interviewees stressed the benefits of multi-disciplinary working, particularly when it comes to the provision of holistic support. Working in mixed professional teams furthermore provides the opportunity to achieve a whole-person-view of service users. For example, the interviewed psychiatrists felt that getting feedback from other team members, especially from nurses who key-work patients, can help them in making decisions that are in line with patients’ priorities. From the perspective of social workers, working alongside health staff in one team constituted a good opportunity to overcome boundaries between the professions and to have a more constructive exchange of different perspectives on mental health.

Changes in training and accreditation

5.62 There have also been a number of developments in the structure of qualifications and the way learning is viewed in general. There is, for one, the move towards a modularisation of all higher education courses in line with the National Plan for the Implementation of the Scottish Credit and Qualifications Framework 2003-2006. Courses, such as the doctorate in clinical psychology, in their new modularised form, have become more flexible, and individual modules can be accessed as part of a person’s continuing professional development. The occupational therapists interviewed for the present study reported that in terms of developing post-graduate training, validation and accreditation of courses offered by a range of agencies in the community had proven to be very successful.

5.63 In some professions there has been a new appraisal of continuing professional development (CPD). Social work, for example, has moved towards a model that recognises the value of ongoing learning and development and has adopted a broad view on what counts towards this. Within social work, one component of CPD has to be about vulnerable people. This means that recovery training, as one of the interviewees pointed out, would be very much in line with CPD requirements.

Multi-disciplinary training

5.64 Interviewees were asked whether they thought it would be best that professional groups were trained in recovery competencies separately or in mixed groups. The overwhelming response was that training would work best if delivered to the teams *within which people already work*. This was thought to have several advantages:

- It would allow teams to link the training to issues that they are actually encountering in their work and to use real examples during the training.
- It would discourage within-discipline resistance to the training and the tendency to make disparaging comments about other disciplines.
- Compared to training with strangers, it would allow people to be more open and honest, instead of “holding their tongue”.
- It would allow people to bring different perspectives, skills and experiences to the training, and to learn from each other.
- It would mean that, if the training is successful, all professionals within the team “buy into” the recovery approach together, which will make its translation into practice much easier.

5.65 Post-registration training within existing teams would also potentially address the difficulty of translating recovery-related training into practice identified by several interviewees. If existing teams through training are able to start and keep working in a more recovery-oriented way it will be easier for new practitioners and students on placement to put their ideas and ideals into practice.

5.66 However, interviewees felt that one piece of training would not be sufficient to allow people to shift towards a recovery-oriented way of working. Any training needs to be followed up in order for the lessons not to be lost and practitioners need to have the time and opportunity to continue to reflect upon their own practice. During the training, goals should be set for the implementation of recovery-oriented work within the team and people need to be supported through supervision in changing their practice where necessary. Some interviewees also noted that, while joint training could be useful, it would be necessary to safeguard the distinct ethics and perspective of each profession.

5.67 People felt that training in multi-disciplinary teams would be possible, but only if certain conditions are met. The psychiatrists interviewed especially felt that many of their colleagues will not attend unless the training is mandatory. In the case of NHS teams, the training has to be made mandatory by the relevant NHS Board. In non-NHS teams, which are often run by voluntary organisations, the management of these organisations could make recovery-oriented

training a requirement for their teams. However, with the introduction of mandatory SVQs for unqualified support staff, it may be difficult for the non-statutory sector to find the resources to fund recovery-oriented training over and above this, in which case the Scottish Executive would have to set it as a requirement.

5.68 When the Tidal Model was introduced in pilot wards in Glasgow, nurses were trained in their teams for a day, which was made possible by bringing in staff from other wards to cover for the team's absence. This may be more problematic in the case of multi-disciplinary teams, and it may be that only one part of the team can be trained at any one time. However, it was noted that most teams have team-away days and that one of these could be used for training in recovery competencies.

5.69 One disadvantage of delivering training to existing teams may be that it limits the extent to which established 'cultures' of practice are challenged, since it does not facilitate discussion between different service providers. An aspect that the students studying for the City and Guilds Level 3 certificate particularly valued about training together with people who work in a range of different settings was that it provided them with a much greater knowledge of the variety of services and resources available in the community. Such an exchange of knowledge would be limited if training would only take place in existing service teams.

CHAPTER SIX CONCLUSION

6.1 This project set out to provide a starting point for the development of a recovery competencies framework for Scotland. It aimed to do so through the sharing of international approaches to recovery competencies with mental health service users, carers, workers and educators and through exploring their views on the development and implementation of a competencies framework relevant to the Scottish context.

6.2 A review of frameworks and guidelines produced in the USA, New Zealand, Australia and the UK, revealed convergence on eight core principles on the basis of which more specific competencies are formulated. These principles are:

- Belief in and understanding of recovery
- Respectful relationships
- Focus on strength and possibilities (not deficit focused)
- Care and support directed by service user
- Participation in recovery of significant others
- Challenging stigma, discrimination, social exclusion
- Provision of holistic services and supports
- Community involvement

6.3 The weighting of particular elements within this set of core principles differed between the countries as did the interpretation of specific elements such as the role of diagnosis. Some approaches contain competencies specific to the historical and cultural context of their countries, e.g. knowledge of Maori culture in New Zealand, or the use of peer support in the USA.

6.4 The response of all participants was that the eight principles identified above are very relevant to promoting recovery in Scotland. Indeed, the essential qualities for mental health workers that participants wrote down before they were presented with the international principles, matched these closely, and further reinforced the importance of a belief in recovery, respectful relationships, and a focus on strength and possibilities. Focus group discussions confirmed the relevance of all the eight principles and put them in the necessary explanatory context but also provided a more complex picture of the competencies and infrastructures needed in Scotland.

Recovery competencies – the Scottish picture

Getting the basics right

6.5 Throughout the discussions participants emphasised the need for putting into practice the basic elements of respectful and caring human relations. Being listened to, recognised as a person, considered as an individual, and treated in a respectful and empathetic manner were central concerns of the participants. Despite many positive examples, service users and carers pinpointed unhelpful relationships with mental health workers, especially with the more powerful professionals such as psychiatrists, as one of the main obstacles to recovery in Scotland. While participants in the staff focus groups felt that they largely already work in a way that is

compatible with the recovery approach, other participants felt that often professionals fail to treat them as equals, impose their own values and preconceptions and ignore the service users' and carers' points of view. Underlying causes for these actions were identified as mental health workers holding stigmatising views of people with mental health problems and only seeing the diagnosis, thereby "putting people in boxes", as well as the dynamics that result when one person in a relationship has power over the other party. Also, participants felt that there is a lack of a challenging culture in Scotland, with people failing to realise that mental health workers work *for them*.

6.6 Mental health workers therefore need to think about how **stigma and power dynamics** affect the work they do with service users. It was suggested that **professional boundaries** could be overcome by mental health workers acknowledging their **shared humanity** with the service user and by introducing an element of **reciprocity** into their interactions. This should result in a relationship in which the professional is **interested in the service user, sees them as an individual and takes them and their experiences seriously**. In such a relationship it will be easier to establish **trust** and for service users to feel that they can challenge any decisions that they feel uncomfortable with. **Involving carers** can be invaluable in the process of finding out about the service user and their experiences, especially when he or she is very unwell, and should be done in the same respectful way.

Moving towards recovery

6.7 Within such respectful relationships, mental health workers need a **belief in and understanding of recovery** to help people move forward. They need to understand that **recovery is an individual process**, with possible frequent set-backs and relapses along the way. Mental health workers not only need to be aware that recovery can sometimes take a very long time but also need to find the right **time and pace** for **challenging** service users to make changes and to reclaim responsibilities in their lives. Mental health workers need to be able to **remain motivated and hopeful** despite the ups and downs of this process. It was noted that sometimes service users themselves may not be motivated to work on their recovery. They may not agree they have anything to recover from, have become disempowered through their past experiences of mental health services or have reached a safe place that they do not want to move from. While this can be an obstacle to the facilitation of recovery, the majority of participants felt that mental health workers should continue to offer opportunities and challenges to people as long as these were in line with the individual person's background and interests. Participants felt that **listening skills** are essential throughout the process and that mental health workers should **focus on people's strengths** and help them to recognise and use these. A **sense of humour** to lighten the mood along the way and **continuity**, which allows mental health workers and service users to build up a bond, were also seen as important.

6.8 Service users felt that **having a say in their care, negotiating their support needs, and setting goals collaboratively** are vital to recovery. At the moment, however, they are often not enabled to direct their own care and support. Once respectful relationships have been established, service users need professionals to **provide more information** about their mental health problem and possibilities of care, especially when they are first diagnosed. They need to be **given different options** for treatment and support, which at present are not often available and

be told about (the possible benefits of) **alternative therapies**. Participants in service user focus groups especially mentioned finding it helpful to be pointed towards self-help techniques such as relaxation. Most importantly, service users have to be allowed to take **responsibility** for their own choices and their **negotiation of risk**.

6.9 Although the majority of participants highlighted the **benefits of receiving a diagnosis** and viewed **medication** as an important factor in the recovery process they stressed the need for mental health workers to be able to look **beyond the medical model** and provide **holistic support**. People need more help with accessing suitable housing, getting support with day-to-day tasks that they may find difficult to manage when they are unwell, and eventually with finding meaningful work. Receiving support for their mental health should also not mean that people's physical complaints are being neglected. While every recovery journey is different, many service users have found receiving support to **use community resources or to develop a role in the community** invaluable. Additionally, mental health workers need to support service users with **coping with and challenging the stigma** that is still attached to mental health problems and especially conditions like schizophrenia.

Overarching themes

6.10 In addition to the emphasis on the basic elements of respectful and supportive relations, a number of overarching themes could be identified in the focus group data. The importance of '**finding the right balance**' was repeatedly mentioned. Many of the competencies outlined above can create dilemmas for mental health workers. Dilemmas may arise between taking participants' (negative) experiences seriously and expressing hope, between creating safety and letting people take risks, or between respecting service users' choices and decisions and facilitating recovery through challenging service users' boundaries. In the majority of cases there are no clear solutions. **Reflective practice** and the ability to balance these principles in a way that lays open pathways for change without putting pressure on service users or disrespecting their boundaries are therefore essential. Similarly, in reciprocity as well as the use of humour, questions will always need to be asked about what is appropriate.

6.11 Finding the right balance is closely linked to another theme that re-emerged throughout the discussions: considering **the individual in the context of their whole life**. Challenges, choices offered, activities, and again reciprocity and sense of humour need to be adjusted to the individual person, their background, personality and ambitions. This makes **an interest** in getting to know each **service user as a person** and **respecting the diversity of people's experiences** core competencies for mental health workers.

6.12 Finally, in all focus groups the competencies that participants discussed were not only about what staff provide or do with service users but were also about staff's own life skills and how they are supported or look after themselves. Participants in the service user and staff focus groups pointed out that in order to be a good mental health worker you need to have **life experience** on which you can draw. How staff look after their own mental health, how they are supported in their work, as well as how staff treat each other were all considered to be crucial factors for the facilitation of recovery.

Training

6.13 Findings from the interviews with educators indicated that the extent to which existing mental health training for the different professional groups is in line with the recovery approach varies. While occupational therapists, clinical psychologists and social workers seem to be taught at least some of the recovery competencies in their training, this is much less the case for nurses, psychiatrists and social care workers (apart from those enrolled on the Certificate in Community Mental Health Care). The majority of the interviewees felt that making training modules more explicitly recovery focused would be possible and in the interest of all stakeholders but would require a shift in the agenda of the regulating professional organisations. While NHS Education for Scotland is now changing the training for mental health nurses, there are no such changes planned by the Royal College of Psychiatrists, the Scottish Social Services Council or the Scottish Qualifications Authority.

Implementation

6.14 The successful implementation of recovery competencies, it was agreed, will require support from government policy and the commitment of managers at all levels. There needs to be a consistent approach to change, rather than a fragmented effort that only includes certain areas or professions, so that mental health workers can see that recovery is an approach that has currency beyond being merely the next new initiative. While change will inevitably be top-down, practitioners need to be consulted and involved in the change process. Existing good practice has to be acknowledged and allowed to continue in its current form.

In training

6.15 Similarly, in order to overcome resistance from educators, initiators of change should carefully consider how a recovery training framework would fit with the existing curricula. It was clear from the responses of those interviewees more directly involved in teaching that there will need to be recognition of the competencies taught already. In order to guarantee the uptake of training opportunities in recovery from as wide a range of professions as possible, it was also considered to be important that people promoting the recovery approach should not take an anti-medical stance.

6.16 There was some disagreement amongst the participants as to what would be the best format for training both new and existing staff in recovery competencies. Some of the participants in the staff focus groups favoured staff rotation as an ongoing means of developing practice, and service users suggested that placements in user-led projects would be very helpful. Staff and educators also highlighted the advantages of delivering training to existing mental health teams. Some of the participants, who had experience of studying or working together with people from different professional backgrounds, stressed the benefits of learning through being challenged and being able to draw on other people's knowledge and experience of a range of services.

6.17 Several interviewees voiced concern that, while recovery compatible practice is being taught in training courses, often newly qualified mental health workers lose some of their idealism and motivation to work in this way when they join teams where different work practices are already established. While multi-disciplinary team training was suggested as one way to overcome this problem, interviewees felt that even such training would not actually change practice unless it is followed up and supported by other measures. Lessons from the Tidal Model suggest that supervision is crucial in this process. However, interviewees working in social work and psychiatry flagged up that in their disciplines adequate supervision is often not in place. Such gaps will need to be identified and support structures put in place in order for staff to be able to reflect on their practice and to be motivated to embrace new ways of working.

Obstacles

6.18 A lack of time and overworked staff were identified in both interviews and focus groups as major obstacles to recovery focused practice. Lessons from the Tidal Model suggest that at least for some professional groups the extra time needed to build up respectful relationships may be offset by a reduction in critical incidents and staff time spent responding to these. However, since other professions may be less affected by labour-intensive practices such as constant observation, it may still be necessary to consider increased staffing levels. The Mental Health Nursing Review (Scottish Executive, 2006a) addresses the need for increased staffing explicitly by recommending that NHS Boards and regions use the National Workforce Planning Framework to anticipate future staffing demands. Similar planning may have to take place in the other mental health professions to allow for a move towards recovery oriented practice.

6.19 An additional system level obstacle to the implementation of recovery competencies in practice is that the benefit system as well as the majority of assessment tools used are deficit-focused. It is therefore important that, like during the Tidal Model implementation, documents and tools used by mental health teams are assessed on their compatibility with recovery and where possible changed over a period of time.

The Scottish challenge

6.20 There were some concerns that the implementation of recovery competencies could be complicated because of some characteristics of the Scottish mentality. Due to a lack of a culture of self-determination and choice, people are not yet comfortable with critiquing professionals and demanding their rights. Service users and carers, as well as professionals in less powerful positions need to be empowered to challenge existing modes of practice and to be open to initiatives relatively new to Scotland such as peer support.

Other areas for development

6.21 A truly recovery focused mental health system needs more than a recovery competencies framework. While mental health workers have much to contribute in supporting people's recovery, most participants felt that input from other service users is also crucial. It was felt that

formal **peer support** needs to be developed more in Scotland, both in the form of groups of people supporting each other, and in the form of peer support workers, i.e. (ex) service users who are trained and reimbursed for supporting others.

6.22 Additionally, in order to make services truly relevant and respectful to service users, they need to have more input in the planning, recruitment for and implementation of services. **Service user involvement** was also flagged up as an issue in interviews with educators, with most courses using service users as guest speakers, but not providing them with more meaningful input into the training. Infrastructures that support and reward real service user involvement therefore need to be developed.

ANNEX 1

Table 4.2: Competency categories generated in post-it task with examples

Competency	Examples
Listening	Someone who actively listens to you //Ability to listen attentively //Ability to listen interactively and critically //Listening but not judging //People who hear what you say //Listening as an individual
Interpersonal qualities	Caring attitude //Compassion //Give people support through illness //Patience //Humility – can learn from service user //Conscientiousness //Approachable //Honesty //Building up a relationship //Trust //Responsibility //Respect //Continuity //Understanding the power dynamic and the effect you might have on another person
Belief in and encouragement of change	Positive attitude //To hold the candle in the darkness of despair //A belief that recovery is possible //Belief in people’s ability to change //True and hopeful //Encourage to try again and keep going //Goal setting //Solution focused //Help me move on
Focus on the individual	Support that is personality appropriate //To travel at the same pace as the individual //Support from someone who understands where you are and where you want to go //Ability to relate to people on a very individual and personal level //Understanding that they were a person before they were a symptom //Respect diversity //Eager to know the carer’s knowledge of the individual’s life and who they really are
Empathy	Empathy and understanding//I found helpful having someone to talk to who understands //Empathy with people from different backgrounds
Knowledge about illness, interventions and resources	Knowledge about mental health //Understanding of patient’s problems and illness //Give the patient a clear insight into his illness //Knowledge of available resources// Early appropriate interventions //Coping mechanism //Dialectic behavioural therapy
Bring out person’s strengths	Value the individual’s potential //They believe in me and what I am capable of //Have the skills to get the best out of people //Encourage me to take risks in improving my life //Challenges //Facilitate people to do things themselves towards recovery
Life experience	Good life skills/experience //A range of background experiences //Recovery from experience of mental health problems
Non-judgmental attitude	Open-minded, non-judgmental //Non-judgmental attitude //Non-judgmental approach
Sense of humour	Sense of humour //The ability to laugh at myself
Others	That mental health is something that affects us all //See past any labels which may have been attracted //The help of friends and family and the wider network //Volunteering gives you something to get up for //To be motivated and to learn new skills/new models of practice to implement in their work // Different way of thinking

REFERENCES

Anthony, W. (1993) 'Recovery from mental illness: The guiding vision of the mental health service system in the 1990s', *Psychological Rehabilitation Journal*, 16, 11–24.

Anthony, W. (2000) 'A recovery oriented service system: setting some system level standards', *Psychiatric Rehabilitation Journal*, 24(2), 159-168.

Anthony, W. (2004) 'Bridging the gap between values and practice', *Psychiatric Rehabilitation Journal*, 28(2), 105-106.

Australian Health Ministers (2003) *National Mental Health Plan 2003-2008*, [Online] Available: [http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs/\\$FILE/nmhp0308.pdf](http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs/$FILE/nmhp0308.pdf). [2006, May 2].

Australian Integrated Mental Health Initiative (2005) 'An interview with Lindsay Oades', *CRM Newsletter* (3), [Online] Available: www.uq.edu.au/health/docs/2005/Issue3.pdf [2006, May 19]

Barker, P. (2001) 'The Tidal Model: developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing', *Journal of Psychiatric and Mental Health Nursing*, 8, 233-240.

Berzins, K. (2006) *Implementing a Recovery Approach in Policy and Practice: a Review of the Literature*, Edinburgh: Scottish Executive, [Online] Summary Available: <http://www.wellscotland.info/live-research.html> [2006, December 10].

Bradstreet, S. (2004) 'Elements of Recovery: International learning and the Scottish context.' In S. Bradstreet, & W. Brown (Eds.), *SRN Discussion Paper Series. Report No.1*. Glasgow: Scottish Recovery Network.

Brown, W. and Kandirikirira, N. (forthcoming 2007) *Recovering Mental Health in Scotland. Report on Investigation of Mental Health Recovery Stories*, Glasgow: Scottish Recovery Network.

Chadwick, P. (1997) *Schizophrenia: The Positive Perspective*, London: Routledge.

Chinman, M., Young, A., Rowe, M., Forquer, S., Knight, E., and Miller, A. (2003) 'An instrument to assess competencies of providers treating severe mental illness', *Mental Health Services Research*, 5(2), 97-108.

Coleman, R. (1999) *Recovery an Alien Concept*, Gloucester: Handsell Publishing.

Coursey, R., Curtis, L., Marsh, D., Campbell, J., Harding, C., Spaniol, L., et al (2000a) 'Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems', *Psychiatric Rehabilitation Journal*, 23(4), 370-377.

Coursey, R., Curtis, L., Marsh, D., Campbell, J., Harding, C., Spaniol, L., et al (2000b) 'Competencies for direct service staff members who work with adults with severe mental illnesses: specific knowledge, attitudes, skills, and bibliography', *Psychiatric Rehabilitation Journal*, 23(4), 378-392.

Curtis, L. (1993) *Workforce Competencies for Direct Service Staff to Support Adults with Psychiatric Disabilities in Community Mental Health Services*, Vermont: The Centre for Community Change, Trinity College of Vermont.

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

Department of Health (2001a) *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*, London: Department of Health.

Department of Health (2001b) *The Journey to Recovery - The Government's Vision for Mental Health Care*, London: Department of Health.

Department of Health (2001c) *Shifting the Balance of Power within the NHS: Securing Delivery*, London: Department of Health.

Department of Health (2003) 'The NHS Knowledge and Skills Framework (NHS KSF) and development review guidance – working draft.', London: Department of Health.

Department of Health (2004) *The Ten Essential Shared Capabilities – A Framework for the whole of the Mental Health Workforce*, London: Department of Health.

Dorrer, N. (2006) 'Evidence of Recovery: The 'Ups' and 'Downs' of Longitudinal Outcome Studies.' In S. Bradstreet, & W. Brown (Eds.), *SRN Discussion Paper Series. Report No.4*. Glasgow: Scottish Recovery Network.

Fisher, D. and Chamberlin, J. (2004) 'Consumer-directed transformation to a recovery-based mental health system', [Online] Available: <http://www.power2u.org/downloads/SAMHSA.pdf> [2006, March 14]

Forquer, S. and Knight, E. (2001) 'Managed care: recovery enhancer or inhibitor?', *Psychiatric Services*, 52 (1), 25-26.

Glover, H. (2005) 'Recovery based service delivery: are we ready to transform the words into a paradigm shift?' *Australian e-Journal for the Advancement of Mental Health* 4(3), [Online], Available: <http://www.auseinet.com/journal/vol4iss3/govereditorial.pdf> [2006, May 3]

Grant, S. (2004) *National Mental Health Services Assessment, Towards Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, Final Report*. Edinburgh: Scottish Executive.

- Jacobson, N. and Curtis, L. (2000) 'Recovery as policy in mental health services: strategies emerging from the States', *Psychiatric Rehabilitation Journal*, 23 (4), 333-341.
- Lafferty S. and Davidson R. (2006) 'Putting the Person First', *Mental Health Today*, March: 31 – 33.
- May, R. (2000) 'Roots to recovery: The roots of a clinical psychologist', *Clinical Psychology Forum*, 146, 6-10.
- Mental Health Commission (1998). *Blueprint for Mental Health Services in New Zealand*, [Online], Available: <http://www.mhc.govt.nz/publications/1998/Blueprint1998.pdf> [2006, May 3]
- Mental Health Commission (2001) *Recovery Competencies for New Zealand Mental Health Workers*, [Online], Available: http://www.mhc.govt.nz/publications/2001/Recovery_Competencies.pdf [2006, February 14]
- Mental Health Commission Ireland (2005) *A Vision for a Recovery Model in Irish Mental Health Services*, Dublin: Mental Health Commission. [Online] Available: <http://www.mhcirl.ie/docs/Vision.pdf> [2006, March 13]
- National Institute for Mental Health in England (2004) *Emerging Best Practices in Mental Health Recovery*, London: National Institute for Mental Health in England, [Online] Available: <http://kc.nimhe.org.uk/upload/Best%20Practices%20in%20MH%20Recovery%20Poster.pdf> [2006, May 2]
- Oades, L., Deane, F., Crowe, T., Lambert, W., Kavanagh, D. and Lloyd, C. (2005) 'Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness', *Australian Psychiatry*, 3(3), 279-284.
- O'Connell, M., Tondora, J., Croog, G., Evans, A., Davidson, L. (2005) 'From rhetoric to routine: assessing perceptions of recovery-oriented practices in a state mental health and addiction system', *Psychiatric Rehabilitation Journal*, 28(4), 378-386.
- O'Hagan, M. (2004) 'Recovery in New Zealand: lessons for Australia?' *Australian e-Journal for the Advancement of Mental Health* 3(1), [Online], Available: www.auseinet.com/journal/vol3iss1/ohaganelitorial.pdf [2006, May 15]
- Ohio Department of Health (1999) *Emerging Best Practices in Mental Health Recovery*, [Online] Available: http://www.mhrecovery.com/best_practices.htm [2006, May2]
- Ralph, R. and Muskie, E. (2000) *A Synthesis of a Sample of Recovery Literature*, Washington: NASMHPD.
- Rickwood (2004) 'Recovery in Australia: Slowly but surely'. *Australian e-Journal for the Advancement of Mental Health* 3(1), [Online], Available: www.auseinet.com/journal/vol3iss1/rickwoodeditorial.pdf [2006, May 4]

- Roberts, G. and Wolfson, P. (2004) 'The rediscovery of recovery: open to all', *Advances in Psychiatric Treatment*, 10, 37-48.
- Sabin, J. and Daniels, N. (2003) 'Strengthening the consumer voice in managed care: VII The Georgia Peer Specialist Programme', *Psychiatric Services*, 54(4), 497-498.
- Sainsbury Centre for Mental Health (2001) *The Capable Practitioner Framework: A Framework and List of the Practitioner Capabilities Required to Implement the National Service Framework for Mental Health*, London: Sainsbury Centre for Mental Health. [Online] Available: [http://www.scmh.org.uk/80256FBD004F3555/vWeb/flPCHN6FMK5Z/\\$file/the+capable+practitioner.pdf](http://www.scmh.org.uk/80256FBD004F3555/vWeb/flPCHN6FMK5Z/$file/the+capable+practitioner.pdf)
- Scottish Executive (2003a) *National Programme for Improving Mental Health and Well-Being Action Plan 2003-2006*, Edinburgh: Scottish Executive.
- Scottish Executive (2003b) *The Mental Health (Care and Treatment) (Scotland) Act 2003*, Edinburgh: Scottish Executive.
- Scottish Executive (2005) *Delivering for Health*. Edinburgh: Scottish Executive.
- Scottish Executive (2006a) *Rights, Relationships and Recovery, The Report of the National Review of Mental Health Nursing in Scotland*, Edinburgh: Scottish Executive.
- Scottish Executive (2006b) *Delivering for Mental Health*. Edinburgh: Scottish Executive.
- Sowers, W. (2005) 'Transforming systems of care: the American Association of Community Psychiatrists guidelines for recovery oriented services', *Community Mental Health Journal*, 41 (6), 757-774.
- SRN (2005) 'The role and potential development of peer support services', *SRN Briefing Paper*, Glasgow: Scottish Recovery Network.
- SRN (2006) *Evaluation of Recovery Based Training for Trainers Pilot*, [Online] Available: <http://www.scottishrecovery.net/content/mediaassets/doc/Final%20report.pdf> [2006, June 6]
- Stocks, M. L. (1995) 'In the eye of the beholder', *Psychiatric Rehabilitation Journal*, 19(1), 89-91.
- Torrey, W. and Wyzik, P. (2000) 'The recovery vision as a service improvement guide for community mental health center providers', *Community Mental Health Journal*, 36(2), 209-216.
- Torrey, W., Rapp, C., Van Tosh, L., McNabb, C., and Ralph, R. (2005) 'Recovery principles and evidence-based practice: essential ingredients of service improvement', *Community Mental Health Journal*, 41(1), 91-100.
- Turner-Crawson, J. and Wallcraft, J. (2002) 'The recovery vision for mental health services and research: a British perspective', *Psychiatric Rehabilitation Journal*, 25(3), 245-254.

Trochim, W. & Cook, J. (1993) *Workforce Competencies for Psychosocial Rehabilitation Workers: A Concept Mapping Project*, Linthicum, MD: The International Association of Psychosocial Rehabilitation Services.

U.S. Department of Health and Human Services (1999) *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

World Health Organization Regional Office for Europe (2005) *Mental Health: Facing the Challenges, Building Solutions. Report from the WHO European Ministerial Conference 2005*. Copenhagen: World Health Organization Regional Office for Europe, [Online] Available: <http://www.euro.who.int/document/MNH/edoc06.pdf> [2006, May 28]

Young A., Forquer S., Tran A., Starzynski M., and Shatkin J. (2000) 'Identifying clinical competencies that support rehabilitation and empowerment in individuals with severe mental illness', *Journal of Behavioral Health Services & Research*. 27, 321-333.

Young, A., Chinman, M., Forquer, S., Knight, E., Vogel, H., Miller, A., Rowe, M., Mintz, J. (2005) 'Use of a consumer-led intervention to improve provider competencies', *Psychiatric Services*, 56 (8), 967-975.