What Works (or doesn't) in Mental Health Recovery Oriented Practice

The Mental Health Recovery Institute

Contents

Introduction

The concept of Recovery emerged from the consumer movement in the 1970s and 1980s. The term has since been used in a variety of settings (notably mental health and drug & alcohol fields) and has been used to refer to a variety of fundamentally different concepts. This ambiguity regarding the definition of the term has led to widespread confusion and oftentimes criticism of the concept it seeks to explain. Over the last decade, the concept has been much refined, and there now exists a large body of works that provide greater clarity regarding definitions of Recovery and its applications.

It is now generally accepted that the term 'Recovery' refers to the experience of the individual in recovery. The term 'Recovery Oriented Practice' is used to refer to the activities conducted by others such as mental health professionals, to support an individual's recovery. These terms are also distinguished from the Recovery Movement, which refers to the political and social movement in mental health, which is providing a voice to the consumer experience.

There has been much debate about current best practice when describing people experiencing mental distress. For our purpose, the terms 'consumer' and 'client' are used to describe people who are recipients of mental health services.

Recovery

While 'Recovery' is now clearly defined as the experience of the individual, there exists a distinction made between 'clinical recovery' and 'personal recovery'. Clinical Recovery is defined as a 'reduction or cessation of symptoms and 'restoring social functioning' (Victorian Government Department of Health, 2011).

Personal Recovery (also called 'Psychological' or 'Social' recovery) is defined by the consumer and refers to an ongoing holistic process of personal growth, healing and self-determination (Slade 2009).
The majority of publications, including mental health policy in Australia, adopt the definition of 'personal recovery' when discussing 'Recovery', and now define this explicitly.

While there remain numerous definitions and interpretations of personal recovery, perhaps the most cited is a statement derived from the US Department of Health and Human Services (2006), who convened over 110 expert panelists, including mental health consumers, family members, providers, advocates, researchers, academics, public officials and others, to review a series of papers and reports. The following National Consensus Statement of Mental Health Recovery was derived from the findings:

> *"Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."*

The consensus statement also identifies 10 fundamental concepts for recovery:

- self-direction and self-determination
- individualised and person-centred care
- empowerment of consumers
- holistic and integrated care

- non-linear journeys of personal growth and healing
- strengths-based approaches
- peer support
- respect
- responsibility
- hope

As an ongoing process, recovery is not concerned with 'achieving' a state of being 'recovered' via treatment of mental illness. Rather, the research suggests that recovery is a non-linear process of continual growth (which may be interspersed with occasional setbacks). The pathway is informed by the individual's unique strengths, preferences, needs, experiences and cultural background (US Department of Health and Human Services, 2006). Therefore, recovery is a highly personal and individualised journey that cannot be standardised or replicated.

Recovery Oriented Practice

Recovery Oriented Practice describes an approach to providing mental health services, which supports people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether or not there are ongoing symptoms of mental illness (Shepherd, Boardman & Slade 2008). Thus a recovery-oriented approach represents a movement away from a primarily biomedical view of mental illness to a holistic approach to wellbeing that builds on individual strengths (Davidson, 2008).

Recovery Oriented Practice therefore encompasses the 10 fundamental Concepts for Recovery, and applies these to the way in which services provide support. Recovery Oriented Practices are those activities which help to create an environment within which personal recovery can occur. The literature outlines a range of practices which are helpful in creating that environment.

Dignity of Risk

The literature suggests that it is important to acknowledge that risk is an inherent part of living, particularly when one lives with mental distress, and that a risk minimisation approach can at times hinder a person's recovery effort. 'Dignity of Risk' refers to a person's right to experience all that life has to offer, even though taking part in an activity may entail some risk (MHCC, 2012). As a recovery oriented practice approach involves promoting consumer choice, agency and self-determination a degree of risk tolerance in services is required (Victoria Department of Health, 2011).

Services need to reconcile their Duty of Care obligations with their obligation to provide Dignity of Risk to consumers. It is therefore necessary for services to articulate a level of risk which is considered appropriate in each service setting.

Decision Making

Self Determination and self management are core principles of Recovery, and thus Recovery Oriented Practice must promote consumer-led decision making in accordance with each individual's values and circumstances.

Competency and the ability to make informed decisions are not questioned. The role of practitioners is to assist the consumer to consider all relevant information and consider a range of options along with potential consequences (Davidson & Tondora, 2006).

Language

The literature on Recovery Oriented Practice consistently highlights the importance of the language used in practice. In promoting recovery friendly environments, the individuals' choice of language should be noted and respected, because language can either encourage or undermine recovery activities. Particular language to note are the individual's choices about what to be called (e.g., 'consumer', 'client', 'survivor', 'peer', etc), and terms such as 'noncompliance' or 'resistance' which suggest that the practitioner holds the authority and power, rather than respecting the consumer's own right to self determination and choice in treatment (Victorian Department of Health, 2011). Terms such as 'psychosis', 'hallucinations', 'delusions' are considered to be disrespectful as they do not encompass and honour the individual's experience. In addition, classifications of people as 'mentally ill' are being replaced by descriptions of 'mental distress' indicating a preference towards appreciation rather than medicalization of the person's experience.

Therapeutic Alliance

Typically, literature on Recovery Oriented Practice promotes a partnership or collaboration between worker and the individual experiencing mental or emotional distress. Some literature characterises the relationship as that of coach and client, rather than as expert and patient, where the latter is considered a passive recipient of care (Oades, Crowe & Nguyen, 2009).

Mead & Copeland (2000) highlight the need to 'discard the kinds of paternalistic relationship some of us have experienced in the past' and look to a 'truly supportive therapeutic relationship [which] begins with honesty and a willingness to take a critical look at assumptions learned during training' (p.320). The importance of minimising power imbalances in the therapeutic alliance is highlighted throughout the literature on Recovery Oriented practice (Deane & Crowe, 2007).

Rogers (1957) argued that the relationship between client and therapist was itself therapeutic and more important than factors such as specific interventions. This view has been endorsed by studies such as that by Lambert (1992) which revealed that the largest single determinant of positive change in mental health was due to the therapeutic relationship (30%), followed by techniques (15%), expectancy and hope (15%) and other factors (40%).

Today, the 'therapeutic alliance' is a validated concept that is robust in predicting outcomes, and does so more powerfully than any other index (Summers & Barber, 2003). However, 'therapeutic relationship' is not to be used as a rationale for non-action or non-direction. A number of proponents have argued for the importance of some active tasks in establishing the therapeutic alliance. Glover advocates against 'cappuccino therapy' where the main focus of intervention is on procuring a hot beverage and consuming it together. Bordin (1979) describes the therapeutic working alliance as comprised of three elements: mutual understanding and agreement about goals; agreement on the necessary tasks to move toward the goals', and; establishment of a bond between the parties involved.

In their chapter, Deane and Crowe (2007) conclude that whether alliance primarily facilitates other interventions or is an active ingredient itself likely depends on the needs and disposition of the client. They warn that though an alliance might be formed by finding common ground, or engaging in non-threatening or recreational activities, the therapeutic relationship should be more than a friendship, and that the practitioner should look for opportunities to engage in meaningful conversations which support recovery goals.

Goals

The literature on Recovery Oriented Practice highlights the importance of goal setting as a vital activity towards recovery. This is not only due to the positive outcomes when goals have been achieved, but also because goal setting itself, has been linked with promoting hope and personal meaning, two important processes associated with psychological recovery (Andresen, Oades & Caputi, 2003; Snyder, 2000).

Locke & Latham's Goal Theory (1990) identified six specific factors which promote goal attainment by enhancing motivation and directing attention:

1) identifying goals that are clearly defined, measurable and difficult
2) setting goals that promote self efficacy and are important to the individual
3) developing strategies or plans to attain goals,
4) setting a time frame for goals to be reviewed,
5) monitoring goal progress and provision for regular feedback about performance and,
6) problem solving potential barriers likely to impede goal progress.

However, it is not just goal setting which is important, but the literature identifies that it is essential that goals are defined by the consumer. Goals that are personally meaningful, promote hope. Unfortunately, too often services are only supportive of certain goals. Lecomte et al (2005) found that the highest levels of agreement were for goals addressing symptoms, and lowest for goals associated with religious or spiritual activities. However, when consumers and clinicians agree regarding the treatment goals, outcomes include increased satisfaction, decreased distress, reduced symptomology, and improved treatment outcome.

Better treatment outcomes are associated with the degree to which the person in recovery is an active participant in treatment and goal setting (Tryon & Winograd, 2001). Corrigan, McCracken & Holmes (2001) advocate for motivational interviews as a means to exploring goals, and ensuring goals are in line with personal values, rather than determined by a checklist of needs and deficiencies.

Homework Actions

It is well evidenced that clients are more likely to improve if they apply the skills learned in therapy to situations outside treatment. In the academic literature, these tasks are referred to as 'homework', and there have been more than 30 separate studies to examine the effect of homework assignments for people in recovery (Kazantzis, 2000).

Homework is considered a core and crucial component of therapy, and there is clearly a causal link between including homework tasks and improved treatment outcome in some cases improvement of at least 60% more and also a correlation between completion of homework tasks with outcome.

The research also indicates that although practitioners report using homework tasks on average in 57% of sessions, only 25% or psychologists and 15% of case managers use a systematic process for determining homework tasks.

Exploring Identity

Existentialism is important in Recovery Oriented Practice and has been found to resonate with people in recovery, as they explore issues of death, isolation, freedom, and meaninglessness. Moore & Goldner-Vukov (2009) assert that 'when ultimate existential concerns are recognised, patients have an opportunity to understand their life on a deeper level that is not defined as a medical disorder, but as a part of human existence… and can free patients from the stigma of psychiatric labels'. Processes to explore issues of identity, including the notion of an 'ideal self' have been shown to have promise in supporting people in mental health recovery.

Holistic, Strengths Based & Positive Psychology

Perhaps the most practical contribution that positive psychology offers to the recovery movement thus far is what we call the "strengths survey" and the larger framework of strengths and virtues it represents (Resnick & Rosenheck, 2006). Recovery Oriented Practice requires a focus on strengths rather than deficit, and wants rather than needs. Practitioners must be willing to view the consumer holistically, and work with the consumer in whatever area they identify as being of important to their recovery.

Journey Metaphor

The metaphor of recovery as a 'journey' is prolific in recovery literature (Queensland Health, 2005). Presently, there are few models for how that concept might be utilised in Recovery Oriented Practice, however some work has been conducted utilising Joseph Campbell's model of 'the Hero's Journey' (1949) as a philosophical underpinning.

The role of the Hero is sometimes misunderstood by consumers and clinicians. It is confused with a leaning for hero worship rather than Campbell's more ordinary meaning of simply 'you' the protagonist, or main character in your own life. We are all 'Hero'.

Peer Support

The role of people with a lived experience in supporting another person's recovery is emphasised in much of the recovery literature. Known as 'Peer Support Workers', people with a lived experience of mental distress, can help to promote hope and role modelling to both colleagues and those in the recovery process. Peer workers must be adequately trained and able to provide support in a constructive manner.

Consumer and Carer Involvement

The literature clearly indicates that consumer and carer involvement at all levels of service delivery is critical for the creation of Recovery Oriented organisations. Consumers and carers can be involved in the

measurement and evaluation of Recovery Oriented practice in organisations through participation in consumer satisfaction surveys, which can inform strategic planning and quality improvement (Davidson & Tondora, 2006). Furthermore, consumers can participate in those strategic planning and quality improvement processes.

Consumer and Carer -led education and training programs can be routinely carried out, with trained consumers as champions of change (Sainsbury Centre for Mental Health, 2009). The literature recommends services consider appropriate debriefing and support mechanisms to facilitate this process.

Policy & Frameworks

The concept of 'Recovery Oriented Practice' is dominant throughout national mental health policy in Australia:

- The 4th National Mental Health Plan 2009 identifies 'social inclusion and recovery' as the first priority area for mental health in Australia and states that services should 'Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models'.
- The vision of the National Mental Health Policy 2008 is for a mental health system that a) enables recovery, b) prevents and detects mental illness early, c) ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.
- The National Standards for Mental Health Services 2010 states in Standard 10.1, Delivery of Care that 'MHS incorporate recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery'.
- The NSW Community Mental Health Strategy 2007 aims to promote the recovery of people with a mental illness or disorder, and places 'Recovery focus' as the central principle guiding community mental health services.
- Sharing Responsibility for Recovery (2005) aims to develop a shared understanding of Recovery and Recovery Oriented systems, initiate discussion on stakeholder responsibilities, and work towards a coordinated framework of Recovery .
- Framework for Recovery Oriented Practice, produced by Victoria Department of Health identifies domains of Recovery Oriented Practice, and within each domain, core principles, key capabilities, good practice examples, and good leadership examples. More recently, non-mental health disability standards have also begun to incorporate the concept of recovery and self determination into policy and standards for service delivery.
- Disability Services Act 2006, Queensland provides 'the strongest foundation Queenslanders have ever had for promoting the rights of people with a disability, increasing their wellbeing and encouraging their participation in the life of the community'.
- Your Life Your Choice Self-Directed Support Framework, launched by Queensland Government in 2012 states that Self Directed Support is an approach which enables people with a disability and/or their family to have choice and control over their disability supports and services to achieve positive outcomes in their lives.

The principles underpinning Self Directed Support mirror those of Recovery Oriented Practice.

Models of Recovery Oriented Practice

In terms of a delineated model which specifies what activities practitioners can undertake with clients to enhance their recovery process, there exist very few.

In Australia, the Collaborative Recovery Model, developed by the University of Wollongong (Oades, Deane, Crowe, Lambert, Kavanagh & Lloyd, 2005) consists of two guiding principles (Recovery as an individual process, and Collaboration and Autonomy support) and four active components (personal life vision, values clarification, goal setting technology, and homework activities).

In the United Kingdom, the Recovery Star (MacKeith & Burns, 2008), a mental health version of the Outcomes Star, developed by Triangle Consulting is gaining popularity. The Recovery Star identifies ten areas of life including: managing mental health, self care, living skills, work, relationships, addictive behaviour, responsibilities, identity and self esteem, trust and hope. The model includes ladders describing a ten step journey for each of the ten outcome areas covered by the tool.

At present, there is a need for a Recovery Oriented Practice model which provides practitioners and consumers with not only a framework to work within, but also effective tools to support their recovery oriented practice.

Implementation of Recovery Oriented Practice

The literature on Recovery also addresses the implementation of Recovery Oriented Practice in organisations, particularly in relation to the challenges faced in adopting such an approach. Uppal and colleagues found in their study (2010) that approximately 37% of the trained clinicians participating in the study were found to be implementing training protocols in clinical practice, and that the average time taken to implement the protocols was 5.6 months following training. The most frequently cited barriers were institutional constraints. Perhaps counter-intuitively, higher caseloads and more frequent client contact were related to a higher level of transfer of training, suggesting that those with more client contact had greater opportunities to implement the skills learnt in training.

In A New Paradigm, Crowe, Couley, Diaz & Humphries (2007) identify that challenges to implementing recovery oriented practice include concerns about additional workload, and the trend of inconsistent long term care relationships, perceived lack of organisational support, and the 'philosophical opposition' barrier, which may be related to potential conflict between recovery oriented practice approach which promotes informed risk taking and traditionally risk aversive care approaches.

Deane, Crowe, King, Kavanagh & Oades (2006) state that even when there is high congruence with national policy, high management support, and strong participation in training, the implementation of recovery oriented practice cannot be assured. Deane et al (2006) cite Becker et al's call for middle managers to not only understand the model, but to communicate this effectively and execute change with staff and other stakeholders. In practice, the authors have found that many organisations assume middle managers understand recovery oriented practice, and therefore are not supported with adequate training or ongoing support to up-skill them in terms of integrating Recovery Oriented practice.

For recovery to become embedded in practice, a culture that supports recovery oriented practice is essential, and demonstrated commitment from leadership and management is necessary (Farkas Gagne, Anthony & Chamberlin, 2005).

In the Victorian Department of Health Recovery Oriented Practice literature review (2011) they identified a number of activities that facilitate movement towards a recovery approach including:

- revising the organisation's goals and aims (mission statement)
- shifting to a consumer empowerment and education model, rather than a purely therapeutic model
- recruiting consumers at all levels, beginning with management
- training for the new consumer workforce in peer support and other community courses
- developing a system of support for peer support specialists
- focusing on meeting new performance targets and flexibly developing new operations

Other studies highlight the inclusion of Recovery Oriented Practice principles in all operational policies and procedures, structures and systems, so that practices facilitative of recovery remain in place regardless of changes to management or staff (Mental Health Coordinating Council 2008).

The literature specifically supports the requirement that professional development and learning, supervision, training, research and performance monitoring are consistent and compatible with principles of recovery. Similarly recruitment practices should incorporate an understanding of recovery oriented practice, so that staff are selected not only for skills and knowledge of recovery oriented practice, but also appropriate attitudes towards recovery. The literature posits that the qualities and attitudes of staff are at least as, if not more, important as their skills and knowledge (Davidson, 2008), particularly because their values and attitudes will inform their approach.

Evidence

Empirical Evidence for Clinical Recovery

Despite early objections to the notion of clinical recovery for people with severe mental illness, the evidence now strongly supports the possibility of clinical recovery. Vermont (Harding et al, 1987) and Maine (De Sisto et al, 1995) challenged the belief that mental illness is chronic, using longitudinal studies that demonstrated that over time, people with severe mental illness recover to the extent that they often have no symptoms. In Vermont, 269 patients discharged from psychiatric facilities were studied over 32 years, and found that between 62% and 68% of former patients had no symptoms at all, or were a lot less troublesome. In Maine, 269 former patients were studied over 35 years, with 49% having significantly improved with only medication post discharge. Similar results were found for a number of longitudinal studies conducted in Germany (Huber et al 1975), Lausanne (Ciompi & Muller, 1976), Zurich (Bleuler 1978), Iowa (Tsuang et al 1979), Japan (Ogawa et al 1987), Cologne (Mameros et al 1989), and an 18 site study conducted in 2001 (Harrison et al, 2001). Some longitudinal studies have found that over two thirds of people with serious mental illnesses experience full or partial recovery (Corrigan & Ralph, 2005).

Consumer Evidence

In addition to the empirical research on rate of Recovery, consumer's own lived experience provides evidence for the possibility of both clinical and personal recovery. Consumer accounts of recovery state 'I am the

evidence!'. Notably, Patricia Deegan, a well-known psychologist, has written and spoken extensively on her experience of recovery (1995).

Evidence Based Practice

The literature suggests that Recovery Oriented Practice and Evidence Based Practice as the two principal propellants of contemporary mental health service improvement, are complementary (Torrey et al. 2005, Davidson, Drake, Schmutte, Dinzeo & Andres-Hyman, 2008). The literature suggests that due to the origins of Recovery Oriented Practice in the Consumer Movement, it is likely that Recovery Oriented Practices will prove to be the most effective way of supporting people experiencing mental distress.

Measuring Recovery and ROP

Clinical recovery can be measured using objective indices such as presence or lack of symptoms, use of medication, days in psychiatric facilities, and measures of psychological distress (E.g., Kessler 10, DASS) functioning (Global Assessment of Functioning), and identified needs(E.g., CANSAS).

Attempts to measure personal recovery are more challenging, because of the subjectively defined nature of personal recovery. Given the complex nature of recovery, best approaches to measuring recovery seem to be scales designed to measure one or more components of Recovery (e.g., hope, responsibility, etc). Tools which can be utilised include Quality of Life Scales, Mental Health Recovery Measure (MHRM) and Recovery Attitudes Scale). The STORI and SISTR have been designed to measure stages of recovery, but as yet have been little tested. Other measures include goal attainment and homework completion.

Recovery Oriented Practice in organisations can be measured by rating the individual and the organisation against indicators of Recovery Oriented Practice such as the Recovery Oriented Services Self Assessment Tool (ROSSAT, NSWCAG, 2011).

Conclusion

The literature on Recovery and Recovery Oriented Practice is beginning to present a consistent message about what is required to support people experiencing emotional and mental distress. The literature emphasises a range of principles and approaches which can be considered good practice within a recovery oriented practice paradigm, including:

- the need for 'dignity of risk'
- consumer to lead decision making
- appropriate use of language
- importance of a strong therapeutic alliance
- meaningful and manageable goals
- consistent use of homework tasks
- exploration of identity
- holistic, strengths-based and positive psychology
- metaphor of 'journey'
- role of peer support
- consumer & carer involvement

It is clear that Recovery Oriented Practice need not replace other modes of operating such as Evidence Based Practice, Person Centred Care, or Trauma Informed Practice, but rather it is complementary and can support those approaches.

The literature clearly indicates that organisational commitment is crucial in facilitating a reorientation towards recovery oriented practice. Embedding a recovery approach also requires incorporation of principles of recovery in organisational processes, policies and procedures, in addition to training, supervision, and ongoing professional development of staff.

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