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## Understanding 'recovery'

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## ARTICLE

Understanding 'recovery'<sup>†</sup>

Glenn Roberts &amp; Jed Boardman

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<sup>†</sup>In the next issue of *Advances*, Roberts & Boardman will consider how the implementation of wider social and economic policies can support peoples' recovery and social inclusion. A commentary on both articles will also be published in that issue.

**SUMMARY**

The principles of recovery have been supported by UK mental health policy and have been incorporated into policy in several countries worldwide. In this article we examine the ideas, principles and definitions of recovery and their origins. Personal recovery is contrasted with clinical recovery and the nature and development of the recovery movement is outlined. The principal factors influencing personal recovery are hope, control and opportunity. In an accompanying article we discuss the implications of these principles for training and practice.

**DECLARATION OF INTEREST**

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

'What's needed most of all is a change of attitude in each Trust from the community nurse to the Chief Executive. [...] it is perfectly possible to live a fulfilling life after a diagnosis [of severe mental illness]. We have no doubt that this is achievable.' (Murray 2012: p. 5)

'Historically people with mental illness were often not expected to recover. [...] Services of the future will talk as much about recovery as they do about symptoms and illness.' (Department of Health 2001: p. 24)

Are we there yet? Probably not, but much has happened since the Royal College of Psychiatrists launched its joint position paper *A Common Purpose: Recovery in Future Mental Health Services* (Care Services Improvement Partnership 2007) and the associated invitation to psychiatrists to consider adopting recovery as their common purpose (Roberts 2007). There is considerable evidence that a major transitional process is underway, supported by increasing international endorsement, focused on developing person-centred, recovery-oriented practice (Le Boutillier 2011). Some have sceptically seen this as little more than appropriation and re-labelling of existing 'good practice' principles (Holloway 2013). Others see it as a radical and challenging approach, derived from civil rights and the personal testimony of service users, that offers a major stimulus for the revision and redesign of both mental health and social care services (Perkins 2012).

It is time for psychiatrists to take stock and consider the implications of becoming 'recovery-oriented practitioners'. The past decade has seen the promotion of a number of values-led drivers for progressive policy, including choice (Roberts 2008), social inclusion (Boardman 2010), personalisation (Alakeson 2012) and the pursuit of well-being (Slade 2010a; Boardman 2012). These are complementary contributions to the desired outcome of enabling people to overcome severe mental health challenges and get on with life as they wish to live it. Our linked articles build on the earlier review by Roberts & Wolfson (2004), which has since become *Advances'* most frequently cited article, and they draw mostly on work over the past 10 years, including major academic overviews (Ralph 2005a; Amering 2009; Slade 2009a; Rudnick 2012), critiques of the recovery concept (see below) and experience of service development in the National Health Service (NHS) and other settings (NHS Confederation Mental Health Network 2012).

Our discussion is divided along what is often experienced as the fault line between clarification of principles (this article) and the struggle to implement these in practice (Roberts 2014). The former is well ahead of the latter but there are signs of accelerating development supported by major research (Bird 2011), implementation programmes (Shepherd 2010; Centre for Mental Health 2012a), the collaborative commitments of non-statutory organisations (Jenkins 2011) and independent reviews (Mind 2011; Rethink 2012).

**Recovery: the origins of ideas and concepts**

The roots of the recovery movement in psychiatry have been traced back to humanistic philosophers, social activists and compassionate clinicians over the past couple of hundred years (Davidson 2010a). However, the contemporary ideas of recovery came to prominence initially in the USA in the 1970s and 1980s when people with personal experience of severe mental health problems declared that their symptoms and incapacities need not permanently impede their achievement of personally valued life goals and their identity did not need to be defined by a disability (Deegan 1996a,b; Ridgway 2001; Davidson 2005). Wallcraft (2009) has highlighted that although 'an understanding that most people do recover from serious mental illness has come

from longitudinal (clinical) research, the “recovery vision” emerged from the writing of survivors’. This service user-led view offered a critique of traditional psychiatry as overly focused on illness, psychopathology and biological treatments and insufficiently focused on the whole person, their strengths, hopes, context and capacity to become active and self-determining in their own recovery. It protested that recovery was ‘an alien concept’ in mental health services, characterised by low expectations and prognostic pessimism (Coleman 2011).

It may be uncomfortable to accept that the recovery movement has arisen from the service user movement, which, since its inception, ‘has highlighted their perception of a lack of compassion in psychiatric services’ (Spandler 2011). Nonetheless, it is challenging to realise that our personal qualities, our kindness and capacity for hope-inspiring relationships (Repper 2003) and ability to support ‘everyday solutions to everyday problems’ (Slade 2012a) may be experienced by the people we work with as more important than our knowledge, qualifications or technical skills.

These personal perspectives are echoed in reviews by regulators (Mental Health Act Commission 2009: para. 1.8) and independent commissions (Rethink 2012), which not only ask practitioners to recognise the legitimacy of these concerns, but also point to the need for a social and attitudinal transformation believed necessary to deal with the stigma and exclusion that is still the common experience of people with mental health problems in most societies (Frese 2009).

The contemporary recovery ethos is therefore based on a set of values, ideas and principles that arose initially in a personal, activist and political context rather than clinical settings, intimately linked to a search by people with mental illness for humane care, social justice, individual rights, citizenship, equality, and freedom from prejudice and discrimination as a basis for living well.

### Recovery and the Royal College of Psychiatrists

The Royal College of Psychiatrists’ joint position paper advocating for recovery as ‘a common purpose’ in future mental health services (Care Services Improvement Partnership 2007) was reaffirmed in its Fair Deal campaign, which described its hopes and commitments (Box 1).

Fulfilment of these ambitious goals has taken longer than the 3-year lifespan of the campaign, but a start has been made in most areas and it is notable that the College’s response to the Care Quality Commission initial consultation, asking

#### BOX 1 Commitments to recovery in the Fair Deal manifesto

The Royal College of Psychiatrists calls for:

- the recovery approach to become better understood and accepted across all mental health specialties
- clear and practical guidance and standards on how mental health services can be recovery oriented
- further research on successful methods of supporting self-management and recovery.

The College itself will:

- work with its partners to develop guidance, advice and audit to support recovery-oriented practice in local mental health services
- ensure that training for psychiatrists promotes the recovery approach.

(Royal College of Psychiatrists 2008: p. 27)

for guidance on its core focus, began with the development of recovery-oriented practice.

The College’s membership of the Future Vision Coalition led to it being a co-signatory of a ‘vision statement’, which prioritised recovery as a key driver for future services and endorsed the ambition that in future ‘workforce training and continuing professional development for mental health workers is built around recovery principles as a matter of course’ (Future Vision Coalition 2009: p. 5).

The influence of this lobbying group was clear in subsequent Labour (Department of Health 2010) and coalition (Department of Health 2011) mental health policy, which adopted recovery as one of its six overall aims, with an associated commitment to ‘test the key features of organisational practice to support the recovery of those using mental health services’ (Department of Health 2011: p. 22). This commitment led to the Centre for Mental Health and NHS Confederation’s Implementing Recovery through Organisational Change (ImROC) programme (Roberts 2014).

Specific endorsements from practising psychiatrists in a wide range of specialties have taken various forms, including a position statement across two leading NHS trusts asserting that ‘recovery is for all’ (South London and Maudsley NHS Foundation Trust 2010), a ‘top 10’ of challenges facing psychiatrists (Farmer 2012) and the current President of the Royal College of Psychiatrists’ campaign on recovery and resilience (Royal College of Psychiatrists 2012).

Psychiatrists in the UK work almost invariably in multiprofessional teams and it is therefore significant that each of the core mental health professions has also made some form of statement

**BOX 2 Understanding recovery: one word, three meanings, five usages**

*Recovery* – commonly regarded as a natural healing response and an approximation to cure (most people get better from most things, most of the time)

*Clinical recovery* – recovery from symptoms and difficulties in response to effective care and treatment as described in most evidence-based guidelines (e.g. National Institute for Health and Care Excellence guidelines)

*Personal recovery* – recovery of a valued pattern of life and living, with or without ongoing symptoms and difficulties, linked to an active personal commitment to working on recovery

*Recovery-oriented approaches and services* – the overall pattern of care, support and

professional practice based on learning ‘what works’ from people in recovery conducted by staff with appropriate qualities and skills in recovery-supportive relationships

*The recovery movement* – a values-led collaborative endeavour of people in recovery, practitioners and many others, working to develop and transform mental healthcare and treatment. This recognises the concurrent value of diverse expertise developed through personal experience, research and training and the benefit of working together in partnership to co-construct and co-produce learning, teaching and change

similar to that of the British Psychological Society (Kinderman 2009: p. 1) that ‘mental health services should fully embrace the recovery approach’.

**International understanding and policy**

The recovery approach in the UK is a product of international collaboration and an open exchange of ideas and innovations from a broad and growing network of recovery researchers and development leads. This has resulted in a largely consistent consensus which has seen recovery explicitly adopted in national policy across England (2001/2011), Ireland (2005) and Scotland (2006), other Anglophone countries, including New Zealand (1998), the USA (2003), Australia (2003) and Canada (2009), and close engagement in Italy (Davidson 2010b) and Northern Europe (Amering 2009, 2012). There are some cultural differences, and initial explorations in some Asian (Ahmed 2012; Thara 2012) and African (Katontoka 2012; Parker 2012) countries have illustrated variations in non-Western concepts of recovery which emphasise the importance of spirituality and a collective, rather than an individual, identity for health (Slade 2012b).

**Defining and redefining recovery**

The many meanings of the word recovery are reflected in its use in mental healthcare services and clinical practice (Box 2). As a ‘natural healing process’ it reminds us of the role of resilience in health, but if equated to ‘cure’ or a return to how things were before the injury occurred or illness began, it points to the limits of achieving a cure when applied to people with long-term conditions

(Whitwell 2005). When used to define a social movement it highlights the key importance of social justice and civil rights to the lives of people with mental health problems.

Personal recovery has at its heart a re-conceptualisation of recovery as a personal process of learning how to live and how to live well with or without enduring symptoms or vulnerabilities. It is concerned with gaining hope, meaning, purpose, choice and control over patterns of living valued by the person themselves (Slade 2009). This shift of perspective has enabled people to redefine themselves from being ‘chronically ill’ to ‘in recovery’, through which the possibility of recovery becomes open to all (Roberts 2004).

There appears to be broad acceptance of the validity of distinguishing between clinical and personal recovery and how people can progress in each, independent of the other. However, some colleagues may still agree with Liberman’s (2012) insistence that symptomatic and functional improvement are essential precursors to recovery and his objection to what he sees as the ‘obfuscating and political nature of consumer views on recovery that are vague, not based on established psychological principles and refractory to an empirically reliable and valid definition.’ His objection highlights the continuing need for research regarding the interrelationship between these domains (see [www.researchintorecovery.com](http://www.researchintorecovery.com)).

The current mental health policy (Department of Health 2011) uses Anthony’s (1993) internationally accepted definition of personal recovery (Box 3) to explain its strategic ambition – ‘More people will recover’ – by stating that:

‘More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.’ (Department of Health 2011: p. 6)

Learning how to support people in achieving these goals is what recovery-oriented practice is all about.

**The importance of words and language**

Oyebode (2004) was concerned that using the term recovery to describe the pursuit of well-being for people who remained ill stretched the meaning of an ordinary word to an unacceptable degree. But hope of recovery, led by people with complex mental health problems, has arisen from this altered usage and its radical redefinition of recovery so as to promote the possibility of living well with a long-term condition. The College emphasised that:

**BOX 3 Definitions of recovery****William Anthony (1993)**

'[Recovery is] a deeply personal, unique process of changing one's attitude, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.'

**Pat Deegan (1996b)**

'The goal of recovery is not to become normal. The goal is to deeply embrace the vocation of becoming more deeply, more fully human.'

**Scottish Recovery Network ([www.scottishrecovery.net](http://www.scottishrecovery.net))**

'Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.'

**US New Freedom Commission on Mental Health (Hogan 2003)**

'A process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment.'

**Simon Heyes (2005)**

'Recovery is not about finding a miracle cure or returning to how things used to be. It's about finding a happier, healthier, more sustainable life that recognises the past, accepts the limitations of the present and is full of hope for the future.'

**South London and Maudsley NHS Foundation Trust (2007)**

'Recovery involves living as well as possible.'

**Substance Abuse and Mental Health Services Administration (2011a)**

'A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.'

**Department of Health (2011)**

Recovery means more people will, 'have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.'

**Mary O'Hagan (2012, personal communication)**

'Recovery is a mental health promotion approach for people with mental health problems.'

**Royal College of Psychiatrists (2012)**

'For many people, recovery is the process of developing a new sense of self, purpose in life and hope. It is a journey for the individual and those close to them in rebuilding a satisfying life. Central to the theme of recovery is resilience which allows for individual strengths and coping skills to surface, in spite of adversity.'

'The language used and the stories and meanings that are constructed around personal experience, conveyed in letters, reports and conversations, have great significance as mediators of recovery processes. These shared meanings either support a sense of hope and possibility or carry an additional weight of morbidity, inviting pessimism and chronicity.' (Care Services Improvement Partnership 2007: p. 6)

Some people value terms such as user, service user, survivor or consumer, others value client or patient, and preferences can change over time. There is also a trend towards adopting the 'people first' language convention of disability movements, i.e. 'I am a person who uses services/I am a person who uses services who has a mental health problem'. This aims to uphold an attribution that someone's primary identity is as a person among other people rather than a segregating conflation of identity with disorder, diagnosis or use of services (Nasaw 2012).

The National Institute for Health and Care Excellence's aspiration of 'offering treatment and care with hope and optimism' (National Institute for Health and Clinical Excellence 2009) may be influenced by the climate of expectation in our clinical settings and whether we engage in a supportive rather than pessimistic or sceptical discourse (Slade 2010b). Done well, this is far more than some illness-avoidant, semantic gymnastics or the imposition of 'recovery-speak'. Rather, it is

about being mindful of our language so as to avoid demotivating and diminishing people through how we speak about them and their problems. This carries through to attempts at conceptual reframing, for example describing treatment resistance as 'delayed recovery' (Montgomery 2010).

Last, with respect to recovery itself, there is a perennial risk of any named approach assuming a life of its own and becoming a 'brand' or 'model' which creates both allegiances and divisions. But this is to mistake the frame for the picture. Although some authors have developed models of the recovery process, such as Andresen *et al*'s Stages of Recovery (Andresen 2006), or Ralph's (2005b) dynamic interactive model, these are maps rather than guides and the individuality of personal recovery is better conceptualised as a hope, goal, ambition, philosophy or journey rather than a model.

Recovery-oriented practice may simply be called 'good practice' in future, but for now there may be considerable value in skilfully deploying these words and concepts so as to connect with an international movement aiming to re-orientate practice, practitioners and services.

**Understanding the key tasks and guiding principles of personal recovery**

Clinicians are familiar with recovery as response to effective treatment. The 'evidence' of evidence-

#### BOX 4 International perspectives on key tasks and domains in personal recovery

- Hope, self-esteem, agency, relationship, transitions in identity (Lapsley 2002)
- Hope, personal responsibility, education, self-advocacy and support (Copeland 2008)
- Finding hope, reestablishment of identity, finding meaning in life, taking responsibility (Andresen 2003)
- Choice, self-determination, relationships, hope (Deegan 1996a)
- Hope, control, opportunity (Repper 2003; Shepherd 2008)
- Positive identity separate from illness, making sense of what has happened, self-managing, valued social roles (Slade 2009)
- Hope, person-drive, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility, respect (Substance Abuse Mental Health Services Administration 2011a)
- Connectedness, hope and optimism, identity, meaning and purpose, empowerment (CHIME) (the REFOCUS programme) (Leamy 2011)

based medicine is that there are demonstrable and reliable benefits from specific interventions in terms of measured improvements in symptoms or functioning. Variations in outcomes from treatment are interpreted as how well people respond to it. In contrast, the emphasis in personal recovery pivots on enabling people to exercise choice and preference in discovering how to move beyond

their problems and get on with their life by figuring out what works best for them (Perkins 2007; Copeland 2008), either independently or through helping relationships based on collaboration and partnership working (Repper 2003).

Alongside the continuing search for treatments which are in themselves more effective, there have been a number of systematic inquiries based on qualitative analysis of personal recovery stories and stakeholder consultations (Lapsley 2002; Scottish Recovery Network 2006; Copeland 2008; Rethink 2009; Substance Abuse and Mental Health Services Administration 2011a). These inquiries have sought to reduce the complexity of personal recovery to just a few pivotal principles that may underpin diverse recovery pathways. The risk is that the vividness and salience of these personal accounts get lost in the analysis, but surprisingly there has been considerable consensus concerning these key tasks (Box 4) or supportive principles (Box 5). These all involve the person becoming active and engaged with working on their own recovery. This may include engagement in conventional treatments but through actively 'using them' rather than passively 'taking them' (Baker 2013), and through recognition that even when people have impaired capacity and are subject to compulsory treatment it is still possible to experience choice as a support for personal recovery (Roberts 2008). Many principles converge on hope, agency and opportunity (Shepherd 2008) and these have been expanded by Leamy *et al's* (2011) comprehensive review to include issues of

#### BOX 5 The guiding principles of recovery-oriented practice

##### Living a life beyond illness

Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.

Recovery represents a movement away from pathology, illness and symptoms, to health, strength and wellness.

##### Hope and control

Hope is central to recovery and can be enhanced by the person seeing how they can have more active control over their lives ('agency') and how others have found a way forward.

##### Self-management

Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. There is no 'one size fits all'.

##### Relationships

In the helping relationship with service users, clinicians move away from being experts to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be 'on tap, not on top'.

##### Social inclusion

People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.

##### Personal identity

Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.

##### Narratives

The language used and the stories and meanings that are constructed have great significance as

mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.

##### Qualities of significant helpers

The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.

##### Family and peers

Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

(Care Services Improvement Partnership 2007; Devon Partnership NHS Trust 2008; Shepherd 2008)

identity, meaning and purpose. There also needs to be full recognition that recovery is hard work (McManus 2012) that needs to be sustained, supported or periodically remobilised over the long periods of time that characterise personal recovery journeys.

Clarification of these guiding tasks and principles in personal recovery provides a rationale for practitioners developing recovery-oriented practice (Roberts 2014). For example, how do we cultivate hope, enable people to be in control of their lives, open doors to opportunity of a life and identity beyond illness, and enable people to find meaning and purpose in both their experience and their lives?

### Understanding concerns, doubts and difficulties with the recovery concept

Few, if any, key concepts in psychiatry are without their detractors and not everyone has been happy with psychiatry's engagement in recovery. However, as a previous editorial in *Advances* underlined, 'An emphasis on recovery is of no value if it is not authentic and both clinically and intellectually robust: doubt and debate are essential elements of a healthy developmental process' (Roberts 2007).

It is a confident and mature profession that can listen and take notice of its critics. It may be uncomfortable but essential to take account of these views if psychiatrists are to avoid the pitfalls inherent in service user concerns that recovery will be professionalised or 'colonised' (O'Hagan 2009) and become the 'next thing' that services will 'do' to people (Social Perspectives Network 2007; Mind 2008; Turner 2011) or 'little more than an NHS slogan' (Together 2012).

Issues have been raised by patients and carers, trainees, practitioners, trainers and managers (Box 6). Even some of the original advocates for recovery have expressed concern about professional involvement, which is valid when adoption of the recovery concept is superficial, tokenistic and detached from the ambitions of recovery approaches to redress power imbalances in traditional services.

A service user-led recovery movement has much to say about empowering people through re-balancing the power and authority of professionals to be 'on tap, not on top' (Shepherd 2008). Some may find this tension and tussle over authority and ownership off-putting, but it is an inevitable challenge if psychiatrists are to be involved with issues of rights and power in an outwards looking and politically informed process aiming to enable people to have authority over their own lives and choice over their care and treatment.

Trainers and trainees therefore need to be well versed in sensitively understanding this critique and the concerns held by people in recovery, colleagues and others, which deepen debate and represent a helpful corrective to superficial or tokenistic engagement.

Davidson *et al's* (2006) review of common concerns and the subsequent Substance Abuse and Mental Health Services Administration (2011b) resource paper seeking to answer these identify many objections as based on misunderstanding or misuse of concepts. However, a conclusive response will only be through demonstration of benefit in terms of improved experience and outcomes for people receiving recovery-oriented services, which is mostly still in the future.

### Are we doing it already?

One of the most commonly heard concerns that is raised in the context of teaching and training on recovery is the assertion that 'it's nothing new, we are doing it already', which has some validity, but endorsement of principles needs to be distinguished from evaluated outcomes. It is clear that many of the underlying values and principles of recovery-oriented practice are not new and many are well described within existing professional and practice guides. For example, there is considerable emphasis on partnership working, choice and person-centred approaches

#### BOX 6 Some concerns, doubts and difficulties with the recovery concept

##### From people who use services

'Recovery has been taken over by professionals as the next thing to do to people'

'It's empty rhetoric and an excuse for cuts'

'It is scary to be expected to be more responsible and in charge of things'

##### From carers and personal supporters

'People will be denied supports and services – to promote "independence"'

'It's unrealistic, people are being set up to fail'

'"Supporting self-management" means responsibility rebounding onto family'

##### From practitioners

'We are doing it already ... it's no different to "good practice"'

'It makes me feel uneasy and guilty about my current practice'

'It has little meaning beyond inducing a certain smug satisfaction in aficionados'

##### From trainees

'How does this relate to the psychiatry I read about in text books?'

'How will this help me pass my exams?'

'It's too vague and woolly and seems to be about everything'

##### From managers

'We're suspicious of enthusiasts. Why does it sound like a religion?'

'I feel pressurised by the "juggernaut" of recovery'

'Recovery-focused practice increases our exposure to risk and liability'

(Derived from: Davidson 2006; Care Services Improvement Partnership 2007; Social Perspectives Network; 2007; Mind 2008; Shepherd 2008; Slade 2009 : pp 217–220; Wallcraft 2009; Substance Abuse Mental Health Services Administration 2011b; Turner 2011; Holloway 2013)

in the College's guide to good psychiatric practice (Royal College of Psychiatrists 2009), which is derived from the General Medical Council's guidelines on good medical practice (General Medical Council 2013). In addition, the emerging descriptions of recovery-oriented risk and safety planning (Boardman 2013) are built on the long-standing Department of Health guidance on best practice in risk management and supported decision-making (Department of Health 2007a,b), which explicitly cites 'positive risk-taking' as a support for personal recovery. An emphasis on kindness, compassion, self-management and personalisation can be found everywhere, from the guiding values of the NHS Constitution (Department of Health 2013) to the content of ubiquitous mandatory NHS e-learning. Even the basic definition of evidence-based practice emphasises the use of judicious judgement and informed choice to support individualised responses (Sackett 1996).

The problem, however, lies in the gap between our published guidance and the continuing and well-documented need to improve the service user experience (National Institute for Health and Clinical Excellence 2011). Listening to people's experiences in acute and crisis services (Mind 2011), we do hear many examples of people being well supported in their recovery through services embodying and implementing many of these principles. But we also hear of people wishing for more 'humanity' from their professional carers and wanting to be treated 'in a warm, caring, respectful way irrespective of the circumstances in which they come into contact with services' (Rethink 2012: p. 8).

Advocacy for recovery-oriented approaches has primarily arisen from people with experience of psychiatric services who have found care and treatment unhelpful and sometimes harmful in their current format. Of course we should be 'doing it already', but the evidence from those receiving services is that we are not – or at least not consistently so (Rethink 2012). Even our professional leads, drawing on very wide experience, describe current services for severe mental illness as 'a broken and demoralised system that does not deliver the quality of treatment that is needed for people to recover' (Murray 2012). At its most ambitious, recovery is described as an agenda for transformation (Shepherd 2010; Perkins 2012) which, as the then Minister of State for Care Services emphasised in the parliamentary debate on mental health, is about 'making the kind of changes that service users have sought for years' (Burstow 2012).

One of the central contributions of the recovery movement may be in re-emphasising existing, but unimplemented, good practice guidance from a service user perspective, in addition to sponsoring many innovative approaches (Roberts 2014) and creating an impetus for action.

### **Commitment and collaboration in support of a recovery orientation**

Despite concerns from multiple viewpoints, the overwhelming impression is that advocacy for a recovery orientation in future mental health services has provided a focus around which has gathered a broad collaboration of statutory and non-statutory services, service users, practitioners and policy makers. Recovery not only appears to be an idea whose time has come (Shepherd 2008), but one that all constituencies want to now see implemented in practice.

If recovery-oriented approaches continue to be a leading driver for change, they may also, in time, be able to deliver the kind of 'strong intellectual foundations' that a past CEO of the NHS considered are currently needed to underpin person-centred medicine 'so that people are enabled to live the life they want rather than having to fit in with professional or commercial views' (Crisp 2012).

The aspiration that recovery could be held as a common purpose in future mental health services (Care Services Improvement Partnership 2007) carried the dual ambition that recovery could become not only an increasingly common experience, as endorsed in the current outcomes strategy (Department of Health 2011), but also a guiding purpose that can be understood and held in common by all participants and providers. At a time of austerity it may also offer a contribution to thoughtfully managing down costs while maintaining a focus on outcomes (Roberts 2014).

Published papers on recovery (Roberts 2008; Goldsmith 2012), anthologies of personal stories (Cordle 2011; Geekie 2011) and programmes for service development (Centre for Mental Health 2012a) are increasingly built on collaborations bridging personal and professional experience.

This is well illustrated in the breadth of cosignatories to the current implementation framework (Centre for Mental Health 2012b) built on a broad coalition (Future Vision Coalition 2009), which proposed that:

'If adopted successfully and comprehensively, the concept of recovery could transform mental health services[...]. Services should be designed to support this directly, and professionals should be trained to help people to reach a better quality of life. This will mean substantial change for many organisations and individuals.' (p. 23)

The emerging understanding of what these changes look like and how they may be achieved, the development of recovery-oriented practice, practitioners and services is reviewed in our second article (Roberts 2014).

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## MCQ answers

1 b 2 b 3 d 4 c 5 c

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**MCQs**

Select the single best option for each question stem

**1 The recovery movement:**

- a has its roots in Plato's metaphysics
- b developed its contemporary ideas in the 1970s and 1980s
- c developed mainly in Northern Europe
- d considers recovery ideas to be well embedded in mental health services
- e is mainly driven by people with a long history of alcohol misuse.

**2 Personal recovery is:**

- a a means of regenerating the economy
- b helped by developing hope and a sense of agency
- c antithetical to clinical recovery
- d an extension of institutionalisation
- e a model of six steps of linear progression.

**3 The guiding principles of recovery-oriented practice include:**

- a use of high-dose antipsychotics
- b frequent admission to hospital
- c the rebuilding of asylums
- d developing a sense of identity
- e emphasising a person's incapacities.

**4 Government policy initiatives which do not support recovery include:**

- a personalisation and personal budgets
- b supported employment
- c increased use of the Mental Health Act 1983
- d citizenship
- e equality legislation.

**5 Recovery-oriented language includes:**

- a lunacy
- b mental retardation
- c people with...
- d incapacity
- e weakness-based approach.