Recovery-Based Approaches to Mental Health

Discussion material

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IMPACT
Improving Adult Care Together

The Health Foundation

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How you can use this discussion material

Before our first session, we'd like everyone to read this ***document which summarises the evidence from research, practice and lived experience about recovery-based approaches to mental health.*** *This is not an exhaustive review but the aim of this material is to spark discussions in your group about your experiences and ideas for change.*

This document outlines the ***main challenges and potential benefits of recovery-based approaches to mental health****, and explores some potential* ***best practices.*** *The review identified the* ***origins of the recovery-based approach*** *in the Mental Health Consumer/Survivor and the Recovery Network Movements. There is also a strong connection with the rise of* ***human rights and the deinstitutionalisation process.***

Whilst there is not a univocal definition of recovery-based practices, the review has identified a set of core values: connectedness, hope, identity. meaning and empowerment. These are also known as the CHIME framework (see Fig 1).

One of the main barriers *identified by the review in the implementation of the recovery-based model is the prevalence of the* ***traditional biomedical model of recovery****. Additionally, the review has also identified some criticisms and limitations of the model, such as the inability to assess 'recovery' as meant by this approach.*

After reviewing the main benefits and barriers to applying the recovery-based approaches in mental health, ***the document includes a series of evidence-based recovery-oriented practices with hyperlinks to some case studies and reports from across the UK.***

At the end of the document, you will find ***a series of questions*** *to support your reflection and the discussion with the others in the group.*

What's the issue?

In recent years, there is a rising attention and effort from practitioners and policymakers to shift **from a traditional medical model to a recovery-based approach to mental health** (Lorien et al., 2020). The main difference between the two approaches rests on the **meaning of recovery:** traditionally**,** diagnosis of **severe mental distress** was associated with **small hope of rehabilitation and improvement** with important implications for stigma and negative impact on the use of services (Erondu and McGraw, 2021). **Recovery-based approaches**, by contrast, promote a different idea of **recovery**, which is not linked to the elimination of the symptom but **to empower the person to overcome the effects associated with their mental health condition** including poverty, exclusion, and satisfaction in life (Turton et al., 2009). Additionally, whilst in the **medical model**, the process of rehabilitation is **led by the professionals,** in the **recovery-based approaches to mental health,** the person struggling with mental distress is **in charge to define their own meaning of 'recovery' and how to reach it** (Jacob, 2015).

The recovery-oriented model of care delivery has existed for over four decades (Hummelvoll et al., 2015). Looking at the evidence, the review has identified the **origins of the recovery approach in activist organisations**, and **in disability movements** (Hummelvoll et al., 2015), more specifically, the **Mental Health Consumer/Survivor Movement** (Turton et al., 2009) and the **Recovery Network Movement** (Smith-Merry and Sturdy, 2013) - See **Box 2.**

The recovery-based model is now recognised as a **service-user led approach** that has become a guiding vision of service provision amongst many practitioners, researchers, and policymakers as well as service users (Turton et al., 2009).

Box 1: Disclaimer about the language used in this document

Mental health has been stigmatised for many decades and it is not a surprise that there is a **whole world** of **discriminatory words** associated with mental illness - think about terms like “psycho”, “schizo”, “loony”, and “crazy” which are still used without reflections or any critical thoughts. Stigma, language and actions are strictly associated - words influence the way we think and, then, behave. *“Words are a barrier to help-seeking and a motivator for making discrimination acceptable”* (Mental Health Foundation, 2019). For this reason, we found it necessary to have a section about the language used in this document.

In line with the WHO training (2019) on ‘recovery’, we wanted **the terminology in this document to be inclusive** and reflect the **variety of evidence and approaches** identified in the review.

“[The way we define ourselves] is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere. Above all, a diagnosis or disability should never define a person. We are all individuals, with a unique social context, personality, autonomy, dreams, goals and aspirations and relationships with others” (WHO, 2019).

During the writing of the document, we acknowledged that **language changes in relation to evolving ideas of disability, mental distress and practises. Different words will be used by different people across different contexts over time**. For example, in relation to the field of mental health, some people use terms such as “people with a psychiatric diagnosis”, “people with mental disorders” or “mental illnesses”, “people with mental health conditions”, “consumers”, “service users” or “psychiatric survivors”. However, we know that others might find some or all these terms stigmatising. However, when citing evidence from the US or certain social movements, “users” and “consumers” were commonly used as terms, especially in the context of recovery-based approaches. Additionally, medical evidence often uses terms such as “mental disorders” or “people with mental illness”.

We also use the terms “people with lived experience, “people who are using” or “who have previously used” mental health and social care services to refer to people who have knowledge and experience of a wide range of mental health and social care services. Please **feel free** to **use** the **words** that you feel **better describe your experience**, taking into account and **respecting** the **experiences of other people**.

The main feature of the recovery-based model is the **shift from cure or the remission of symptoms of mental distress to a more holistic approach to recovery** (Weaver, 2021). Whilst the review found that there is still **not a univocal definition of recovery** in the mental health care system (Slade et al., 2013), the most cited one in line with the recovery-based principle is the one proposed by Anthony (1993):

'Recovery is a deeply personal, unique process of changing one's attitude, values, feelings, goals, skills and roles of a person. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by the illness'.

Turton et al. (2009) identifies as the **key attributes** of a recovery-oriented approach:

- Promotion of autonomy,
- Self-management,
- Treatments reclaiming identity (including physical, sexual, spiritual, group, and cultural identity) and that support individuals in meaningful activity (such as education and employment)
- Linked to the previous points is the elimination of the stigma attached to severe mental distress and developing self-awareness, self-acceptance, and self-esteem.

Studies have shown that people treated with a recovery-based approach have **better quality of life** and the **50% of people** diagnosed with schizophrenia **experienced good outcomes** (Erondu and McGraw, 2021). For this reason, recovery-based practices and services have been promoted worldwide as a more **person-centred and holistic approach** to mental health (Hummelvoll et al., 2015).

Whilst there is general agreement on **the values and principles behind the recovery model** (see The CHIME Framework in **Fig. 1**), the review has identified an heterogeneity and complexity of the procedures and modalities that lead to recovery (Klevan et al., 2023; Turton et al., 2009; Bifarin and Jones, 2019). This is also reflected in the **inability to create a tool to assess the real effectiveness** or to **define the outcomes of a recovery based approach to mental health** (van Weeghel, 2019; Penas et al., 2019; Erondu and McGraw, 2021). For this reason, it is very complicated to show the real effectiveness of recovery-based interventions.

Another important barrier identified to the implementation of the recovery-based approaches is the different idea of recovery that characterised **the traditional biomedical models of mental health** (Erondu and McGraw, 2021; Walsh et al., 2017). In particular, Erondu and McGraw's review (2021) highlighted the organisational priorities centred on maintaining safety and clinical treatment for symptom control, which are deeply rooted in the traditional mental health model, as one of the main barriers to the use of recovery models in community mental health services in England.

Box 2: Activism, human rights, and citizenship

The World Health Organization (2022) states that the **right to participate** is an essential feature of the **right to the highest attainable standard of health.** Participation in decisions regarding the treatment and in the community are an important element of philosophy behind recovery-based approaches (Klevan et al., 2023). This model, in fact, stemmed from various civil rights movements starting from the 1960s (McCartan et al., 2022), as a response to stigma and suppression in the psychiatric system, and they are based on ideas of human rights and empowerment.

Criticisms of the medical approach to mental illness started during the late 1950s and 1960s. These led to the process of closing down and reducing beds in the psychiatric hospital, known as **deinstitutionalisation** (Novella, 2008). The deinstitutionalization movement supported the entitlement of people affected by mental illness to live their life in the community, rather than being isolated in institutions. This was also fuelled by the rise of human rights which rejected the horrible conditions of life of people affected by mental illness in long stay hospitals and also supported the idea of the right to choice in terms of treatment and health (Novella, 2008).

After long-stay psychiatric hospitals closed (or reduced the number of beds), these movements continued their campaign **to reduce the power imbalance existing in the traditional psychiatric system**, to increase the importance given to the **experience of people with lived experiences** of mental health difficulties and **shift the focus from diagnosis and symptoms to strengths and resilience** (Arches Recovery College, 2024). In particular, **in the US, consumers/survivor**s criticised the traditional psychiatric system because it fostered disability, alienation, oppression and marginalisation (Ahmed et al., 2012).

The term ‘recovery’, as it is used by the recovery-based approach, appeared for the first time in the 1980s through the consumer/survivor movement (Ahmed et al., 2012). The central idea of the **recovery revolution was that mental illness is only one element in the life of a person** (Ahmed et al., 2012). For this reason, recovery cannot be reduced to the ‘cure’ of the symptoms but encompasses the illness to pursue a full, meaningful despite illness (Anthony, 1993). In contrast, the **recovery model** promises **self-determination**, **shared decision-making**, **community involvement**, **advocacy**, **decreasing stigma** and **discrimination**, and a more hopeful picture of outcomes for individuals with psychiatric illnesses (Ahmed et al., 2012).

Supporters of the recovery-based approaches call for a **shift away from the paternalistic nature of biomedical approaches**, towards partnerships that acknowledge and **support the decisive role that service-users and families play in defining and enacting their own recovery and wellbeing** (Strand et al., 2017). For this reason, an integral part of recovery is also connected to human rights and citizenship (Klevan et al., 2023; Sayce, 1999). Social conditions, inequity, marginalisation and stigma in mental health can have very negative effects on

people's lives and possibilities. Klevan et al. (2023) argue that *'recovery emerges through citizenship, rather than citizenship being a prerequisite for recovery*'. Their review identified the 5 Rs - Rights, Responsibilities, Roles, Resources and Relationships - as an essential prerequisite to recovering citizenships (Klevan et al., 2023).

Hampshire County Council, together with PA Consulting, explored how smart devices like the Amazon Echo could improve the lives of people receiving social care. This project focused on using consumer technology as an alternative to traditional telecare equipment, as it is generally more user-friendly, offers extra features like access to audiobooks and radio, and is less likely to stigmatise users. The trial involved 50 adults and assessed whether voice-activated technology could promote independence and wellbeing. The results were encouraging, showing that Alexa devices reduced social isolation and provided reassurance to families, who could receive notifications through the device. Financially, the project was beneficial, with estimated savings of £7,700 for the six-month trial and around £66,300 for 50 users over a full year. In addition, 72% of participants reported that the technology improved their lives, and 68% felt it helped them maintain their independence. A special Alexa Skill was developed to help care workers log and share information more efficiently, supporting the wider care system.

However, the project faced challenges, including ensuring compliance with data governance policies, particularly as the development of Alexa skills handled personal data. Recruiting volunteers for the trial and managing issues with Alexa devices activating prematurely raised concerns. Additionally, the fast-paced evolution of Amazon's product features posed a risk, as new functions could potentially overlap with the features developed during the trial (Hampshire County Council, 2018; PA Consulting, 2024a; PA Consulting 2024b).

What is the context across the four UK countries?

Recovery-based approaches to mental health have been widely included in the politics of mental health across most of the English speaking countries (Ahmed et al., 2013). In particular, the USA, New Zealand and Australia were the pioneers in including this approach in their mental health provision (Ahmed et al., 2013). In 1997, the Mental Health Commission for New Zealand published a Blueprint for Mental Health Services in New Zealand: How Things Need to Be (Ahmed et al., 2013). This was the first time that recovery was specified as a guiding priority for the provision of national mental health services.

Influenced by the example set by New Zealand**, Scotland** was the first of the UK nations to take a recovery-based approach. Following devolution from the UK government, the adoption of recovery as a driving force for Scottish mental health policy and practice was one of the key points (Bradstreet and Mcbrierty, 2012). One of the four key aims of the Scottish Government's National Programme for Improving Mental Health and Wellbeing is promoting and supporting recovery from mental health problems, including severe mental

illness (Brown and Kandirikirira, 2007). The implementation of this policy was strongly supported by the Scottish Recovery Network, which was launched in 2004 (Bradstreet, 2006). The Scottish Recovery network includes a variety of organisations and individuals with an interest in raising awareness of recovery and in looking at new and innovative ways to promote recovery from long-term mental health problems and mental illness.

The Scottish Recovery network's main aims are:

- To raise awareness of recovery from long-term mental health problems
- To gather and share information about the factors that people identify as having helped or hindered their recovery
- To encourage local action and to highlight approaches that we believe to be particularly effective in promoting recovery (Bradstreet, 2006).

In England, personal recovery is strongly advocated for within mental health service delivery policies, such as No Health without Mental Health and the Five Year Forward View for Mental Health (Bifarin and Jones, 2019; Perkins and Slade, 2012). Personal recovery, more specifically service user's recovery, is also a central element of the Care Programme Approach (Bifarin and Jones, 2019). However, various pieces of evidence stressed the strong contradiction between the predominant medical model of mental health and the shift to a recovery approach in England. Bifarin and Jones, for example, highlighted the contrast between nurses training and the reality of practices. Others stressed the difficulties of implementing a recovery-based approach in psychiatric hospitals, where the biomedical model is at core of institutional practices (Lorien et al., 2020). Additionally, Perkins and Slade (2012) highlighted that recovery in England is largely led by professionals with a psychiatric rehabilitation perspective, rather than by service users.

In Wales, the Mental Health (Wales) Measure 2010 led to a restructuring of mental health services (Weaver, 2021). The Welsh Government has decided to write this law to improve and restructure core mental health services, both at primary and secondary levels of care (Weaver, 2021). Weaver (2021) acknowledges that the new mental health services structure is underpinned by recovery principles on the basis of two rationales:

- First of all, it emphasises self-management and independence through increased treatment within primary care, along with reduced dependency upon secondary services.
- Second, the law promotes self-management and co-production in collaboration with a care coordinator, according to the holistic recovery approach provided in the form of the Care Treatment Plan (CTP) (Weaver, 2021).

In **Northern Ireland,** the Bamford Review in 2007 led to important improvements in care for people with mental health problems, including a significant reduction in long stays in mental health hospitals and more people living in the community. As a consequence more attention was given to recovery and development of criteria to assess it (McCartan et al., 2022).

Whilst the establishment of Recovery Colleges has embedded a recovery-oriented practice in mental health services and ensured a greater number of peer support workers and a

positive shift towards a recovery based- approach, Wilson et al. (2015) noted that lack of funding and contradictory conceptualisation of 'recovery' are still limiting the implementation the embedding of the recovery ethos in the services. Findings from the research, highlighted that a medical model is still the dominant in Northern Ireland (Wilson et al., 2015).

The meanings of recovery: Recovery-based VS biomedical models of mental health

Although the exact **definition of recovery remains ambiguous,** there is consensus that recovery does not necessarily imply only the 'cure'. However, Bifarin and Jones (2019) noted that health professionals, and often people using mental health services, are not aware of this distinction and confuse recovering (the process) with recovery/recovered (the outcome). The main reason for this misunderstanding is that the biomedical model is still prevalent in mental health care not only in the UK but internationally (Bifarin and Jones, 2019).

In brief, **the traditional medical model of mental health** mainly looks at the physical causes of mental distress and recovery as the absence of the symptom (e.g. voices, hallucinations, panic attack). It follows that pharmacological treatments are acknowledged as the main means to reach recovery/cure. It is important to highlight that this is a very simplistic explanation and this document is not dismissing the role played by biomedical interventions - often a mix of the two approaches is needed to support the person. However, this definition is aimed to highlight the **main differences in the meaning of recovery for the two approaches to mental distress.**

There are **two main and different meanings of term 'recovery**' in mental health systems internationally:

1. The Biomedical/traditional model aims to a **clinical** (or scientific) **recovery**: in other words to a recovery from mental illness,

2. The Recovery-based approach aims to a **personal** (or social) **recovery** meaning recovery with a mental illness.

Both meanings are underpinned by a **very specific set** of **values** and create role expectations for mental health professionals which is also reflected in a wider debate about the core purpose of mental health systems (Slade et al., 2013).

To better understand this difference, we have added a simple table which is part of a training on recovery model created by the WHO (see **Table 1**).

Traditional/clinical understanding	Recovery approach
• *When a person is no longer behaving strangely.* • *The person is no longer a danger to themselves or others.* • *The symptoms have subsided. For example, the person no longer hears voices.* • *The person is compliant with medications and the doses are stable.* • *A decision has been made by medical staff to discharge the person from an inpatient service.* • *The person's family feels that their relative is better.*	• *When people feel they have control of their life back and can play a role in society.* • *When people using services have a better understanding of their emotional distress.* • *People feel that they are more independent.* • *People may still have symptoms but they are living with them and leading a fulfilling life.* • *When people have emotional distress as part of a person's life, but this is not the centre of their lives.*

Table 1: Source WHO (2019) Recovery Practices for Mental health and Well-Being (p.3)

Supporters of the recovery-based approach argue that the biomedical model of recovery is associated with **negative beliefs** that once a person is affected by mental illness there is **no hope for 'recovery'** - because this is linked to the elimination of the illness (Turton et al., 2019). This has been criticised because it **reinforces stigma about mental illnesses** and it has a negative impact on seeking help and accessing mental health services (Turton et al., 2019; Walsh et al., 2017). Additionally, the biomedical idea of recovery is associated with a more **passive role** in the therapeutic process **of the person affected by mental illness** (Strand et al., 2017; Perkins and Slade, 2012). Recovery-based approaches, by contrast, support an idea of **'recovery'** that puts the **person** at the **centre of any choice** (See **Box 2**). The reduction/treatment of the symptom is only one of the different outcomes expected by the process of rehabilitation (Leamy et al., 2011; Anthony, 1993; Martinelli and Ruggeri, 2020). Therefore, **recovery** has a **wider meaning** along the whole life, this is called **'holistic meaning of health'** and it includes factors which are not strictly clinical such as employment retention, the role of the family, and social support (Hummelvoll et al., 2015)

Recovery models help to challenge negative attitudes and assumptions that people living with severe mental health conditions can only get worse. As such, it is imperative that the service user is embedded in the therapeutic relationships and involved in the whole process of care planning (Grundy et al, 2016; Martinelli and Ruggeri, 2020).

According to the **CHIME framework** (Leamy et al., 2011), one of the most applied in recovery-based approaches (McCartan et al., 2022), there are five complementary processes that need to occur to achieve recovery:

1. **Connectedness -** This describes the sense of being positively connected to other people. This can occur through peer support or within the community. A sense of connectedness can also be fostered through positive healing relationships with health professionals.

2. **Hope** - The importance of hope in recovery cannot be understated. There can be no change without the belief that a better life is both possible and achievable. This can often require a leap of faith and belief that recovery is possible.

3. **Identity** - This refers to the maintenance or construction of a positive sense of self. It necessitates a rejection of stigma and stigmatising beliefs. It challenges us to see beyond the identity of service users.

4. **Meaning** - We all find meaning and purpose in different ways so this can be deeply personal. For some it may overlap with their sense of connectedness, for others it may relate to their faith. Many find it when they begin to feel recognised as a valued and valuable piece of our common tapestry.

5. **Empowerment** - This refers to one's belief in one's own capacity to take the wheel in recovery. Supporters can also empower us by emphasising choice, autonomy, and strength. We can empower ourselves by fostering what is known as a growth mindset - the belief that abilities are developed through dedication and hard work. This mindset is associated with a love of learning, growth and resilience (Leamy et al., 2011; McCartan et al., 2022)

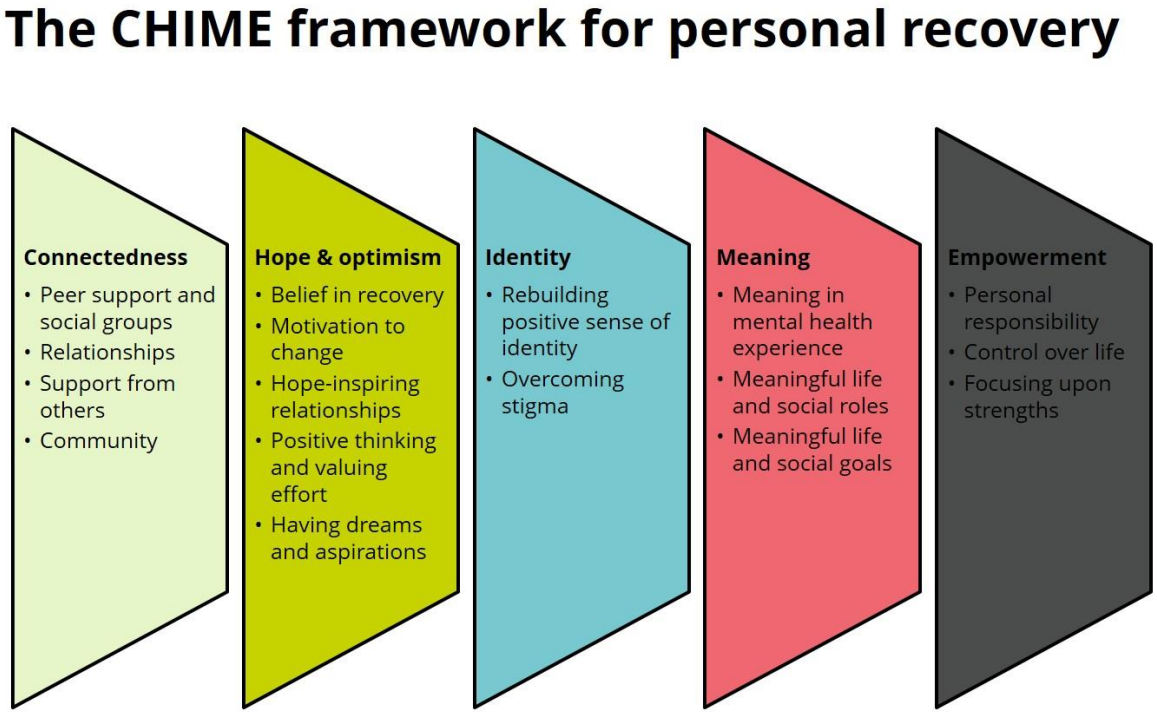

Fig 1. The CHIME framework for Person Recovery (Source McCartan et al., 2022)

Benefits of a recovery-based approach to mental health

The evidence review highlighted that a recovery-based approach has positive implications both for people using services and practitioners (Martinelli and Ruggeri, 2020).

1. **Better outcomes for people with mental distress**

As seen, one of the main features associated with a recovery-based approach is 'hope' (Leamy et al., 2011; Turton et al., 2019). Contrary to a traditional model of mental illness, recovery-oriented practices support the idea that a good life is possible despite a diagnosis of severe mental illness (Anthony, 1993; Turton et al., 2019).This has been linked to an increased and more stable use of mental health services (Erondu and MacGraw, 2021).

2. **Reduction of health costs**

In their review, Martinelli and Ruggero (2020) found that recovery-based approaches reduce mental health care costs because they favour the integration of multiple services in the community. This is also reinforced by the responsibilisation of the person using the services which become the expert of their recovery (Turton et al., 2019; Jacob, 2015).

3. Greater value on the **personal knowledge of the individual and balance in the power** which historically was held by psychiatrists and professionals in the mental health care services (Martinelli and Ruggeri, 2020).

In line with the principles of the movements (See Box 2) that promoted the recovery-based approaches, the therapeutic relationship should be characterised by an equal contribution. The professional and the lived experience of the person affected by mental distress are characterised by two different types of knowledge which have equal value in the recovery process (Martinelli and Ruggeri, 2020). This empowers the person with lived experience (Jacob, 2015) but it has also been associated with greater job satisfaction for the professional (Martinelli and Ruggeri, 2020). Lorien et al. 's (2020) study on recovery-based interventions in hospital settings found their effectiveness in enhancing the recovery knowledge and attitudes of mental health professionals. Recovery-based interventions have the potential to reduce the use of physical restraints and improve work satisfaction among mental health professionals (Lorien, Blunden, and Madsen, 2020).

4. Martinelli and Ruggero's review (2020) also found that recovery-oriented practices lead to a **better focus on the personal priorities of the service user** rather than on the best interests of the service user defined by the professionals.

Barriers and critiques to the implementation of the recovery- based approaches

The evidence review found different studies exploring the barriers in implementing recovery-oriented practice (See Erondu and MacGraw, 2021; Martinelli and Ruggeri, 2020).

The most important barrier identified in the literature is linked to the critiques and misunderstandings towards **the meaning of recovery** (Martinelli and Ruggeri, 2020; Mc Cartan et al., 2022). Some authors reflect on the fact that recovery-based approaches could lead to false expectations - as if a person affected by severe mental illness could also avoid symptoms (McCartan et al., 2022). Others noted that even if recovery-oriented approaches include social interactions as an element of the recovery, practices are still too individualistic

and do not take into account the wider the social context where the person lives (Davidson, 2005). Another important critique to the recovery-based approach is the link to the neoliberal agenda (McCartan et al., 2022). Some authors noted that recovery-based approaches are only another excuse to reduce fundings for people who are struggling with mental distress (McCartan et al., 2022; Davidson, 2005) and others also expressed concerns about the oversimplification that this approach has towards mental distress (Bonney and Stickley, 2008; McCartan et al., 2022).

Another important issue concerns the problem in **measuring recovery-oriented approaches** (Penas et al., 2019) and as a consequence, there is **a lack of evidence-based applications** (Martinelli and Ruggero, 2020). This is due to two main linked reasons:

1) There is a general lack of clear definitions of what is a 'recovery-based practice' (Turton et al., 2019).

2) The recovery model emphasises the process rather than the outcome (Klevan et al., 2023).

In other words, the idea of recovery is supposed to be dictated by the person affected by mental illness and for this reason, this can have a different meaning for every person (Davidson, 2005; Jacob, 2015). More specifically, criticism is also around the CHIME framework in itself. For instance, van Weeghel (2019) recommended that a broader framework of recovery is needed, and more research is needed into the working mechanisms of personal recovery processes (van Weeghel, 2019). As such, it is very difficult to assess and quantify the intervention (Penas et al., 2019). The NHS has applied the Recovery Star as a tool to evaluate rehabilitation (Kadir and Fenton, 2021). However, the review found contradictory results on the validity of this tool to assess recovery (Kadir and Fenton, 2021; Killaspy et al., 2012). A review of the tools developed to assess recovery approaches and services identified very few tools which guarantee the assessment of the process of personal recovery (Penas et al., 2019). Therefore, researchers are recommending more studies on the effect of recovery-oriented interventions and on the knowledge and attitudes of mental health professionals to improve recovery-oriented practice (Sreeram, Cross and Townsin, 2021).

Evidence also highlighted **the challenges for the organisations/services to implement recovery-based approaches.** Martinelli and Ruggeri (2020) in their review found that in order to create services that are properly recovery-oriented, it is not enough that some practitioners decide to implement this approach. The whole organisation/service needs to be adjusted to the recovery values but this could be very challenging, time and resource intensive (Martinelli and Ruggeri, 2020).

Finally, other evidence has focused on **the difficulties experienced in specific sectors or fields.** For example Lorien et al. (2020) have looked at the implementation of the recovery approach in mental health hospital settings; or Bifarin and Jones (2019) explored how mental health nurses training clashes with the requirement of applying recovery-oriented

practices. These are mainly associated with having **the biomedical model of mental health (see previous section) as the predominant model in mental health care** (Lorien et al., 2020). Whilst recovery-based approaches are aimed to empower people drawing on mental health care services, literature shows that mental health professionals are not equipped to provide recovery-oriented care to those accessing services (Sreeram, Cross and Townsin, 2021).

Recovery-oriented interventions

Martinelli's and Ruggeri's review (2020) has identified a series of recovery-oriented practices that have proved to be evidence-based - we have listed them below with a brief description and, when available, we have added a link to practices from the UK.

- Peer support workers - This practice refers to the introduction in services and organisations of 'experts by experience' who use their lived experience to support others to recover.

- Advanced treatment directive - Generally speaking, these treatments are designed to establish what are a person's preferences for treatment, in case the person becomes unable to communicate those preferences to treatment providers and it is usually used for end-of-life medical decisions. However, this is also applied in mental health to support the person when they are in crisis (Srebnik and La Fond, 1999).

- REFOCUS - A program of research, funded by the NHS National Institute for Health Research (Programme Grants for Applied Research), from 2009 to 2014 at King's College London. The aim of REFOCUS was to find ways of making community-based adult mental health services in England more recovery-oriented.

- The Strengths Model - Developed in the mid-1980s, it is both a philosophy of clinical practice and a set of tools and methodologies. Its founding assumption is that the identification and strengthening of the strengths of the person and his/her environment, rather than the identification of his/her deficits and attempts to "repair" them, can facilitate the recovery processes

- The Individual Placement and Support (IPS) model - This is a psychosocial intervention aimed to support the person during their employment. The NHS England is investing in this programme - in the link you will find some case studies.

- The Recovery Colleges - Originally developed in the US, there are a number of Recovery Colleges spread around the 4 UK nations. Recovery Colleges (RCs) are physical establishments which offer a possibility of change and transformation for people wishing to rebuild their lives. They can be defined as formal learning institutions that strive to create environments in which people with a lived experience of mental distress feel safe,

welcome and accepted (Anfossi, 2020). In the link, you will find a short report on the state of Recovery Colleges across the UK.

- Supported housing - "Supported housing services offer a safe environment in which people can recover and build their confidence, helping them to feel more able to live independently in their local community. The term supported housing is used to describe a range of different types of provision, with varying levels of, and approaches to, staffing and support. Effective supported housing services provide residents with support to manage their mental and physical health needs. Individuals are encouraged to establish goals linked to independent living, including finding work or education opportunities, and learning household skills such as cooking or money management" (Definition from Rethink report - in the link)

- Mental health trialogue - These meetings are community forums where service users, carers, friends, mental health workers, and others with an interest in mental health participate in an open dialogue. In the link, there is a report from the Mental Health Trialogue Network Ireland (2012).

Having read the material above, in the first Local Network Meeting, we'd like you to discuss:

Using **Table 1 on the meaning of recovery** - What does recovery mean to you? Do you agree with any of the statements - is there anything missing?

Your experiences…

- Would anyone like to share their experiences of 'recovery-based approaches in mental health'?
- What helps or makes it difficult to implement these approaches?

Thinking about this discussion document…

- Does anyone in the group have experience of any of the practices (e.g. peer support workers, Recovery College) described in the discussion material? Or is aware of other good practices/models to support the recovery of people with mental distress?
- Were there any ideas in this document that you think could facilitate the recovery of people with mental distress?
- Anything in the document you didn't agree with, or didn't match your experience?

Next steps…

- Are there any next steps you'd like to agree as a group? Anything you'd like to discuss?
- Do you think there is anyone else who should be involved in your meeting?

- Is there anything you need from the IMPACT team?

References

Ahmed, A.O., Buckley, P.F., and Mabe, P.A. (2012) Recovery: International efforts at implementing and advancing the recovery model. *International Psychiatry*.1;9(1):4-6. PMID: 31508108; PMCID: PMC6735050.

Anthony, W.A. (1993) Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4):11-23. doi:10.1037/h0095655 Available at https://recoverydevon.co.uk/wp-content/uploads/2010/01/Recovery_from_Mental_Illness_Anthony_1993.pdf

Arches Recovery College (2024) The Recovery Approach. Available at https://www.archesrecovery.ie/what-is-recovery-education/the-recovery-approach/

Bifarin, O. O. and Jones, S. (2018). Embedding recovery-based approaches into mental health nurse training. *British Journal of Mental Health Nursing*, 7(5), 234–240. https://doi.org/10.12968/bjmh.2018.7.5.234

Bonney, S. and Stickley, T. (2008) Recovery and mental health: a review of the British literature. *Journal of Psychiatric and Mental Health Nursing*. 15(2):140-53. doi: 10.1111/j.1365-2850.2007.01185.x. PMID: 18211561.

Bradstreet, S., & Mcbrierty, R. (2012). Recovery in Scotland: Beyond service development. *International Review of Psychiatry,* 24(1), 64–69. https://doi.org/10.3109/09540261.2011.650158

Brown, W. and Kandirikirira, N. (2008) *Recovering Mental Health in Scotland: Report on Narrative Investigation of Mental Health Recovery.* Glasgow: Scottish Recovery Network.

Davidson, L. (2005). Recovery, self management and the expert patient – Changing the culture of mental health from a UK perspective. *Journal of Mental Health,* 14(1), 25–35. https://doi.org/10.1080/09638230500047968

Davidson, L., and Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health,* 16(4), 459–470. https://doi.org/10.1080/09638230701482394

Erondu, C., and McGraw, C. (2021). Exploring the barriers and enablers to the implementation and adoption of recovery-orientated practice by community mental health provider organizations in England. *Social Work in Mental Health*, 19(5), 457–475. https://doi.org/10.1080/15332985.2021.1949426

Jacob, KS. (2015) Recovery model of mental illness: a complementary approach to psychiatric care. *Indian Journal of Psychological Medicine* 37(2):117-9. doi: 10.4103/0253-7176.155605. PMID: 25969592; PMCID: PMC4418239.

Hummelvoll, J.K., Karlsson, B.E., and Borg, M. (2015). Recovery and person-centredness in mental health services: roots of the concepts and implications for practice. *International Practice Development Journal*, 5, 1-7.

Kadir, S. and Fenton, K. (2021) Staff perspectives on using the Recovery Star in mental health inpatient rehabilitation services. *Mental Health Practice.* doi: 10.7748/mhp.2021.e1466

Killaspy, H., White, S., Taylor, T.L., and King, M. (2012) Psychometric properties of the Mental Health Recovery Star. *British Journal of Psychiatry.* 201(1):65-70. doi: 10.1192/bjp.bp.111.107946. PMID: 22753854.

Klevan, T., Sommer, M., Borg, M., Karlsson, B., Sundet, R. and Kim, H.S. (2023) Toward an Experience-Based Model of Recovery and Recovery-Oriented Practice in Mental Health and Substance Use Care: An Integration of the Findings from a Set of Meta-Syntheses. *International Journal of Environmental Research in Public Health*. 18;20(16):6607. doi: 10.3390/ijerph20166607. PMID: 37623190; PMCID: PMC10454698.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., and Slade M. (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*. 199(6):445-52. doi: 10.1192/bjp.bp.110.083733. PMID: 22130746.

Lorien, L., Blunden, S., and Madsen, W. (2020). Implementation of recovery-oriented practice in hospital-based mental health services: A systematic review. International *Journal of Mental Health Nursing,* 29(6), 1035–1048. https://doi.org/10.1111/inm.12794

Martinelli, A. and Ruggeri, M. (2020) An overview of mental health recovery oriented practices: potentiality, challenges, prejudices, and misunderstandings. *Journal of Psychopathology,* 26:147-54. https:// doi.org/10.36148/2284-0249-353

McCartan, C., Mulholland, C., and Ciaran, S. (2022) Recovery-oriented mental health services: An international scoping review. Impact Research Centre Available at https://www.impactresearchcentre.co.uk/site/wp-content/uploads/2023/12/Impact-Centre-QUB-Recovery-Scoping-Review.pdf

Meehan, T. J., King, R. J., Beavis, P. H., and Robinson, J. D. (2008). Recovery-based practice: do we know what we mean or mean what we know? *Australian and New Zealand Journal of Psychiatry,* 42(3), 177–182. https://doi.org/10.1080/00048670701827234

Ng, F., Newby, C., Robinson, C., Llewellyn-Beardsley, J., Yeo, C., Roe, J., … Slade, M. (2022). How do recorded mental health recovery narratives create connection and improve hopefulness? *Journal of Mental Health*, 31(2), 273–280. https://doi.org/10.1080/09638237.2021.2022627

Novella, E.J. (2008) Theoretical accounts on deinstitutionalization and the reform of mental health services: a critical review. *Medical Health Care Philosophies.* 11(3):303-14. doi: 10.1007/s11019-008-9123-5. Epub 2008 Feb 13. PMID: 18270804.

NHS (2021) Individual Placement and Support offers route to employment for people with severe mental health conditions Available at https://www.england.nhs.uk/mental-health/case-studies/severe-mental-illness-smi-case-studies/individual-placement-and-support-offers-route-to-employment-for-people-with-severe-mental-health-conditions/

O'Brien A, Murphy L, Hunt A, Dwyer D, Hunter A. (2024) A co-created multimethod evaluation of recovery education in Ireland. *Health Expect.* 27(2):e13937. doi: 10.1111/hex.13937. PMID: 38549203; PMCID: PMC10978797.

Penas, P., Iraurgi, I., Moreno, M.C., and Uriarte, J.J. (2019) How is evaluated mental health recovery?: A systematic review. *Actas Española de Psiquiatría*. 2019 Jan;47(1):23-32. Epub 2019 Jan 1. PMID: 30724328.

Perkins, R., & Slade, M. (2012). Recovery in England: Transforming statutory services? *International Review of Psychiatry*, 24(1), 29–39. https://doi.org/10.3109/09540261.2011.645025

Ramon, S., Healy, B., and Renouf, N. (2007) Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*. 53:108–22

Sayce, L. (1999). *From Psychiatric Patient to Citizen: Overcoming Discrimination and Social Exclusion.* London: Bloomsbury Academic. Retrieved September 3, 2024, from http://dx.doi.org/10.1007/978-1-349-27833-6

Smith-Merry, J., & Sturdy, S. (2013). Recovery in Scotland: The Rise and Uncertain Future of a Mental Health Social Movement. *Society and Mental Health*, 3(2), 114-132. https://doi.org/10.1177/2156869313481225

Srebnik, D.S., and La Fond, J.Q. (1999) Advance directives for mental health treatment. *Psychiatric Services*.50(7):919-25. doi: 10.1176/ps.50.7.919. PMID: 10402612.

Sreeram, A., Cross, W., and Townsin, L. (2021). Effect of recovery-based interventions on recovery knowledge and attitudes of mental health professionals, regarding recovery-oriented practice: A quantitative narrative review. *International Journal of Mental Health Nursing*, 30(5), 1057–1069. https://doi.org/10.1111/inm.12897

Strand, M., Gammon, D., and Ruland, CM. (2017) Transitions from biomedical to recovery-oriented practices in mental health: a scoping review to explore the role of Internet-based interventions. *BMC Health Service Research*. 7;17(1):257. doi: 10.1186/s12913-017-2176-5. PMID: 28388907; PMCID: PMC5385090.

Thornicroft, G., Ruggeri, M., & Goldberg, D. P. (2013). *Improving mental health care [electronic resource] : the global challenge.* Chichester: Wiley-Blackwell.

Turton, P., Demetriou, A., Boland, W., Gillard, S., Kavuma, M., Mezey, G., … Wright, C. (2011). One size fits all: or horses for courses? Recovery-based care in specialist mental health services. *Social Psychiatry and psychiatric Epidemiology*, 46(2), 127–136. https://doi.org/10.1007/s00127-009-0174-6

van Weeghel, J., van Zelst, C., Boertien, D., and Hasson-Ohayon, I. (2019). Conceptualizations, Assessments, and Implications of Personal Recovery in Mental Illness: A Scoping Review of Systematic Reviews and Meta-Analyses. *Psychiatric Rehabilitation Journal,* 42(2), 169–181. https://doi.org/10.1037/prj0000356

Walsh, F.P. Meskell, P. Burke, E. and Dowling, M. (2017) Recovery-based Training in Mental Health: Effects on Staff Knowledge and Attitudes to Recovery. *Issues Ment Health Nurs*. 38(11):886-895. doi: 10.1080/01612840.2017.1346014. Epub 2017 Jul 26. PMID: 28745921.

Weaver, N. (2021). Recovery and care continuity experiences of people in mental health care: A conciliatory approach to the challenge of implementing recovery-based services. *Sociology of Health & Illness*, 43(9), 1996–2014. https://doi.org/10.1111/1467-9566.13373

WHO (2022) World Mental Health Report: Transforming Mental Health for All. World Health Organization: Geneva, Switzerland.

Wilson, G., Montgomery, L., Houston, S., Davidson, G., Harper, C. and Faulkner, L. (2015) Regress? React? Resolve? An Evaluation of Mental Health Service Provision in Northern Ireland. Action Mental Health: Queen's University Belfast. Available at https://www.amh.org.uk/wp-content/uploads/2010/06/AMH-Study-Final-version-inc-cover.pdf

Wolf, J., Lawrence, L. H., Ryan, P. M., & Hoge, M. A. (2010). Emerging Practices in Employment of Persons in Recovery in the Mental Health Workforce. *American Journal of Psychiatric Rehabilitation,* 13(3), 189–207. https://doi.org/10.1080/15487768.2010.501294

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