

**DISCOVERING HOPE FOR RECOVERY FROM A BRITISH PERSPECTIVE -
A review of a sample of recovery literature, implications for
practice and systems change**

Piers Allott, Mental Health Recovery Educator and Senior Research Fellow
Linda Loganathan, Mental Health Recovery Educator and Research Assistant
Centre for Community Mental Health, University of Central England in
Birmingham

"But now I look back on it with a real sense of achievement. It was a 24-carat crack-up and I'm proud of the fact I got through it, rebuilt myself, did ok as a journalist again, and went on to do what I do now. I couldn't have done what I've done in this job without believing what I believe very strongly, and being tough-minded, focussed, mentally and physically fit. I feel the breakdown and the recovery played a big part in all that."

Alastair Campbell, the prime minister's director of communications and strategy in Sunday Times Magazine, Sunday 6th January 2002

INTRODUCTION

The concept of recovery and development of recovery orientated services and practices are well advanced in other parts of the world and particularly in a significant number of states in the US and in New Zealand. The concept in the UK is only just beginning to be recognised and is demonstrated, in the last 12 months, through the significant number of conferences on the subject.

Given this, the principal author approached the West Midlands Mental Health Development Team with a view to developing a British perspective on recovery. A small amount of funding support was provided to deliver three pieces of work;

- a) to train as a mental health recovery educator and deliver one mental health recovery training
- b) produce a literature review and
- c) complete a sample of interviews with people in the West Midlands about their recovery experiences.

The principal author trained as a mental health recovery educator with MaryEllen Copeland in the US in November 2000 and delivered the first two day Wellness Recovery Action Plan (WRAP) training in January 2001. This training was so successful that it led to calls for ways of disseminating the information particularly from service users and family members and led to the establishment of the Recovery Network within the West Midlands. The Recovery Network was launched at a two day 'Focus on Recovery' conference in May 2001 and at the end of 2001 had nearly 200 members. This paper is the literature review and a sample of interviews will be completed by April 2002.

In addition the principal author brought together an 'International Conference on Recovery Research, Evaluation and relationship to Outcomes' that was addressed by international 'experts by experience' and by training in October 2001 that was focussed on Local Implementation Team Leads, members of the national Expert Group on Outcomes and members of the Development Team for the National Institute for Mental Health in England. It is hoped that this paper will add to the swiftly developing interest and knowledge base on recovery in the West Midlands and the United Kingdom.

BACKGROUND

Recovery from severe and persistent mental illness is a concept which has arisen out of the developing consciousness of the rights of marginalized and socially excluded people beginning with the civil rights movement in the 1960's and 1970's. Recognition of the position of women and black people in western societies led to a growing consciousness and resulting anti-discriminatory legislations which attempt to redress the balance and ensure protection of the rights of these groups. Developing consciousness within groups of disabled people has had similar outcomes in the 'Americans with Disabilities Act' and the 'Disability Discrimination Act' in the UK. However, people with diagnosed mental illnesses remain marginalized in the UK as in many other countries. However, the slowly developing national and international service user movements are beginning to raise a new consciousness of the possibility of recovery from serious mental illness. In the UK the Government has recently approved the main planks of its new policies for mental health; Modernising Mental Health Services, The National Service Framework for Mental Health and the NHS Plan that together state a clear and comprehensive plan for mental health services that places people who use services and their family members at the centre of service planning, development and delivery. It demands service users and family members are involved as equal partners at every level, to ensure that new services are responsive to needs. This will provide the frameworks within which recovery orientated services can be conceived, planned and implemented.

Historically, people with mental illness were not expected to recover. People given diagnoses of schizophrenia were seen by mental health professions as having a poor prognosis with the illness taking a uniformly downwardly spiralling course. Emil Kraepelin at the beginning of the 20th Century judged the outcome of 'schizophrenia' to be so poor that he named the 'disorder' "dementia praecox," or premature dementia. Negative perceptions of severe and persistent mental illness have been maintained for many years and, it could be argued, have contributed to the development of stigma in western societies. This has influenced the public view of people diagnosed mentally ill as being 'unable to take control over their own lives'. By implication this means that people diagnosed with 'mental illnesses' are 'dangerous' resulting in often negative public and public service responses.

Such negative expectations and experiences have severely affected the lives of people who have mental health experiences and those who support them, their families and friends. Such negative expectations continue to exist in the UK today and many of the people treated by psychiatry are placed in a position of 'learned helplessness' (Deegan, 1992) by the mental health system within which such negative beliefs and attitudes provide little or no hope of recovery.

HOPE AND THE POSSIBILITY OF RECOVERY

It is as a result of the developing 'consumer' movement in the United States and other countries, such as Sweden, in the late 1970's and early 1980's that pioneers among people who experienced mental health problems, and their resultant 'treatment' within the mental health system, were able to record their experiences. People like Judy Chamberlin, with the publication of her book 'On Our Own' (Chamberlin, 1978), led the way in telling their stories.

Writings about recovery by people who have experienced mental distress have grown significantly since the 1980's (Deegan, 1988; Leete, 1989) and have

mushroomed in the 1990's so that there is now a very significant literature of writing by people with recovery experiences. In addition, professionals have become interested in this rich literature and begun more clearly to identify the meaning of 'recovery' and seek ways in which this new information can contribute to better and more effective 'treatment'. However, much of the literature and research in this field has been carried out by professionals in countries other than the UK (Davidson, 1992; Tooth, 1997; Topor, 1998) and tends to be inaccessible, published in journals difficult to obtain or papers that are unpublished.

Recovery is a concept that has been introduced by people who have recovered from mental health experiences rather than one that the majority of mental health professionals have conceived, believed and promoted. Some personal definitions of recovery include:

"Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start againThe need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution." (Deegan, 1988, p. 15).

"Having some hope is crucial to recovery; none of us would strive if we believed it a futile effortI believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us." (Leete, 1989).

The evidence of recovery from severe mental illness is not new as the following table of results from seven follow-up studies of people diagnosed with schizophrenia demonstrates (Table 1 below).

Table 1 Results from seven follow-up studies of patients with the diagnosis schizophrenia.

	No. of Patients	Length in years	% Subjects Recovered and/or improved significantly
Bleuler 1968, Zurich	208	23	53-68
Ciampi & Muller 1980 Switzerland	290	37	57
Tsuang et. al. 1979 Iowa US	186	35	68
Huber et. al. 1980, Germany	502	22	56
Ogawa et. al.	140	27	57

1987, Japan			
Harding et. al. 1987, Vermont, US	269	32	68
DeSisto et. al. 1995, Maine US	99	35	49

Source: META Services, Inc. Arizona, 2000 - After Harding - www.metaservices.com/Articles/recovery.pdf

"These studies have consistently found that half to two thirds of patients significantly improved or recovered including some cohorts of very chronic cases. The universal criteria had been defined as no current medications, working, relating well to family and friends, integrated into community and behaving in such a way as to not be able to detect having ever been hospitalised for any kind of psychiatric problem."
(Harding, 1994)

However, even given this evidence, the concept of recovery within the UK is still very limited. The majority of people served by the mental health system in the UK are given little hope of recovery from their experiences when the staff who work with and support them have little if any knowledge about recovery or about ways in which recovery can be supported.

The concept of recovery within professional circles in the United States became more recognised following the publication of 'Recovery from Mental Illness: The guiding vision for the 1990s' in which William Anthony synthesised the writings of people with experience of recovery in his definition:

...a person with mental illness can recover even though the illness is not "cured"... [Recovery] is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness
(Anthony, 1993)

Recovery has been described in many different ways as a process, an outlook, a vision, a guiding principle. Instead of focussing on symptomatology and relief from symptoms, a recovery approach aims to support an individual in their own personal development, building self-esteem, identity and finding a meaningful role in society. Recovery does not necessarily mean restoration of full functioning without support, including medication; it does mean developing appropriate supports and coping mechanisms to be able to deal with mental health experiences rather than being given supports by mental health services, traditionally known as rehabilitation.

RECOVERY AS A NEW PARADIGM WITHIN THE CONTEXT OF RESEARCH - THE NE PARADIGM AND PREVAILING KNOWLEDGE

It is important to take a contextual view of recovery as a developing new paradigm. Thomas Kuhn, a historian of science, offers insights about how emergent knowledge begins to challenge prevailing knowledge within the scientific field. (Kuhn, T. S. 1970) If a person diagnosed with a serious mental disorder can recover without psychiatric intervention or using unorthodox methods, fundamental assumptions of the necessity of treatment and services from the mental health field are challenged. A scientific revolution is in the making.

Paradigm shifts are a necessary part of life. Things do change and we need to adjust to change. Recovery research is mirroring the process of life and our understanding of self. It may appear to be fragmented and uncoordinated, but shares many commonalities with individuation.

'There is no linear evolution; there is only a circumambulation of the self.'
(Jung, C.J. 1965)

The current stage of research into recovery from serious mental illness Kuhn would describe as exploratory. Discoveries are random. Sometimes research is just 'puzzling'. As people begin to integrate new information, research begins to establish itself as 'normal' and is part of a 'coordinated and coherent view and is aimed at fine-tuning the ingredients of effective and accepted practice.' (Knight 2000:8) This may take many years and is often an arduous process. Kuhn argues that there is no way to measure 'progress' in research. Real progress, the paradigm shifts are totally revolutionary.

It usually takes a long time to effect a paradigm shift, often about 20 years. Different phenomena are seen as important to explain, making it impossible to objectively determine which one is better.

CHRONICITY AND SERIOUS MENTAL DISORDER

Topor (2000) examines the questioned paradox. If a chronic illness is expected to have a long life span, usually extending to the whole of a persons lifetime, recovery presents a challenge to the idea of chronicity in relation to schizophrenia and other serious mental disorders.

'The image of the schizophrenic as someone qualitatively different from other people, occurs in diverse psychiatric traditions and underscores the notion that the total breakdown of the ego is the foremost reason for chronicity.'
(Topor 2000)

In addition the term 'chronically ill' is attached to people whose illnesses have been long-term ill and long-stay patients in psychiatric hospitals.

Being admitted to a hospital for psychiatric treatment was for a long time a simple criterion of chronicity. Problems occur where in recent years it has become possible to offer treatment, care and support through crisis resolution and home treatment teams in peoples natural communities that is as effective or better than hospitalisation. Definitions of chronicity remain attached to people with diagnoses of serious mental illness despite contrary evidence. With deinstitutionalisation and the closure of psychiatric hospitals, functional disability replaced chronic illness as a new criterion.

'The cause of chronicity, which has long been sought within the individual (biological or psychological characteristics) is not inherent in the illness itself, a part of the natural order, but rather is clearly connected with the person's life in society.'
(Topor 2000)

Stigmatisation ensures that people whom psychiatry defines as chronic assume psychiatry's definition of themselves thus creating a self fulfilling prophecy (Becker, H.S, 1963). The label of chronicity produces behaviour expected of chronically mentally ill people. Extreme environmental stressors may produce symptoms similar to those associated with mental illness. (Bettelheim, 1943) The chronic course of development

in the condition is not inherent in the illness, but as a result of the lifestyle of the patient. Thus the biography becomes the biology.

RECOVERY - PROCESS OR GOAL?

Definitions of recovery within the literature and the consumer movement in the USA have broadened our understanding of the concept of recovery. At its simplest recovery can be defined as 'a subjective experience of having regained control over one's life.' (Knight 2000) The achievements of those who have recovered embrace hope, empowerment and social connectedness

Schizophrenia is generally thought of as a chronic illness and it would therefore constitute a contradiction in terms to find a higher percentage of diagnosed people who have recovered. However, it has been clearly demonstrated that nearly 50-70% of people with a diagnosis of schizophrenia do recover but rather than simply a condition or state, recovery is more, it is:

'a process of a new self image, an ego that is not completely subjected to the illness, an ego that means that the patient is not entirely helpless in relation to the illness.'

(Strauss et al, 1987)

This ego is not restored to a state prior to the illness. In the active role of recovery the goal is not normalisation but:

'a way of living a satisfying hopeful and contributing life, even within the limitations caused by the illness.'

(Anthony 1993)

With an emphasis on the subjectivity and psychological aspects of recovery, there is a danger that 'the recovery process becomes as long-lived as chronicity.' (Topor 2000:43) In aiming to provide a singular consumer definition of recovery from schizophrenia, which proved impossible, many people maintained that they considered themselves to be just 'getting on with their lives'. (Tooth et al, 1997)

RECOVERY THEMES

A service user-run business in Ohio was asked by a county mental health board to develop and implement an evaluation strategy to identify strengths and weaknesses in the county mental health system. These service users agreed that recovery was important, and generated a list of indicators, as well as ways professionals could be evaluated based on their impact on the recovery process - both positive and negative. These indicators, used in a pilot study in Ohio and in Maine with service users/survivors who had been admitted to the state institution at least once in the last seven years, were rated from most important to least important similarly by both groups. (Ralph, Lambric, & Steele, 1996; Ralph & Lambert, 1996) Ohio consumers rated the indicators in this order. The top four were the same top four rated by Maine consumers:

1. The ability to have hope
2. Trusting my own thoughts
3. Enjoying the environment
4. Feeling alert and alive
5. Increased self esteem
6. Knowing I have a tomorrow
7. Working with and relating to others
8. Increased spirituality

9. Having a job
10. Having the ability to work

Ridgeway (2001) analysed four early consumer recovery narratives (Lovejoy, 1984; Deegan, 1988; Leete, 1989; Unzicker, 1989) with a constant comparative method to find common themes. These themes are as follows:

1. Recovery is the reawakening of hope after despair.
2. Recovery is breaking through denial and achieving understanding and acceptance.
3. Recovery is moving from withdrawal to engagement and active participation in life.
4. Recovery is active coping rather than passive adjustment.
5. Recovery means no longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self.
6. Recovery is a journey from alienation to purpose.
7. Recovery is a complex journey.
8. Recovery is not accomplished alone - it involves support and partnership.

In a review of recovery literature, Ralph (2000) identified four dimensions of recovery found in personal accounts. These are:

1. internal factors - those factors which are within the consumer,
2. him/herself such as the awakening, insight, and determination it takes to recover;
3. self-managed care, an extension of the internal factors where consumers describe how they manage their own mental health and how they cope with the difficulties and barriers they face;
4. external factors which include interconnectedness with others, the supports provided by family, friends, and professionals, and having people who believe that they can cope with and recover from their mental illness; and
5. empowerment - a combination of internal and external factors - where the internal strength is combined with interconnectedness to provide the self-help, advocacy, and caring about what happens to ourselves and to others.

RECOVERY FROM SERIOUS PSYCHIATRIC ILLNESS, INCLUDING SCHIZOPHRENIA

Tooth et al (1997), using Personal Construct Theory, examined recovery from schizophrenia from a consumer perspective. Longitudinal studies reviewed by Harding et al found a recovery or significant improvement rate of between 46 -68% of patients with schizophrenia (Harding et al 1987). Harding et al. have identified ways of separating out the residual effects of the disorder from the effects due to institutionalisation and other associated factors. McGory (1992) and Anthony (1993) also identify stigma, restricted choices, low self-expectation as factors contributing to chronicity in people with serious mental illness.

The Tooth et al (1997) study was designed to answer the following questions:-

1. What factors do consumers who identify themselves as recovered from schizophrenia consider the most important in their recovery?
2. What factors are reported most frequently?
3. What factors identified by the consumer group are similar to those identified in the outcome literature?
4. What factors identified by the consumer group are different to those identified in the outcome literature?
5. What do consumers define as recovery from schizophrenia?

Sixty participants were screened for a previous diagnosis of schizophrenia and were recruited through advertisements in local newspapers, through hospitals and consumer groups. Participants had to be self identified as recovered from schizophrenia. Fifty-seven men and women between the ages of 20 and 65 participated in the research. Using individual interviews and focus groups, participants were asked to identify what they considered the most important factors in their journey of recovery and what was helpful. The results were then systematically analysed. Eight categories were identified as follows:

1. The process of coming to terms with the disorder
2. Activities that were helpful
3. Environmental factors
4. Medication
5. Aspects of themselves that were helpful
6. Their network
7. Hospitalisation
8. Factors which did not facilitate recovery

The role of self was the most frequently reported theme, with the person's determination to get better and manage their illness. Accepting the illness, identifying the crisis response and working with their ability to recover from the illness emerged as significant themes. Participants identified the importance of their social network and having friends who affirmed them and their experiences regardless of the illness. Taking action, facing problems and making choices are consistent with the notion of 'internalised personal agency' (Tomm in Tooth et al 1997:53) Over time in the struggle to recover, participants had externalised the problem of schizophrenia and moved beyond the limitations of the illness.

From responses in focus groups, 53% of participants named optimism and hope for recovery as significant. An equal number reported stigma as a negative aspect. Forty-nine percent identified the importance of spirituality in their recovery and a majority of participants identified a turning point in their journey of recovery.

Topor et al (1997) have made an in-depth study of 'turning points' on the journey of recovery from serious psychiatric illness. In selecting participants, only people are included who had an absence of admission into institutional care for a period of at least two years prior to the interview. Although at the time of the interview some participants were in touch with psychiatry, individuals were living a 'normal life' in society. Five persons were interviewed using a semi-structured interview guide, two women and three men between the ages of 32 and 51 years. Three had received a diagnosis of schizophrenia and two were diagnosed for personality disorders and affective psychosis. Two of the informants can be considered as recovered and three as socially recovered. Warner (1994) distinguishes between 'social recovery' and complete recovery. Social recovery implies that the former patient functions socially, but may still display some clinical signs of disorder such as hearing voices or having certain paranoid delusions. Recovery is regarded as a process (Deegan, 1988) and the former patient may still pay regular visits to psychiatric outpatient care for medication and/or therapy. Complete recovery implies that the former patient no longer displays any psychotic symptoms and has returned to the pre-illness level of functioning. (Warner, 1994) The analysis of the transcripts used grounded theory methodology. One theme in particular - 'turning points' emerged as dominant in the five narratives.

The results which emerge from this study go in some way to address the issue of recovery and chronicity. A 'turning point' and 'the upward journey is not a straightforward linear process' (Topor 1997:15) The breakdown and hitting bottom involves a descent to a place which 'is characterized by feelings of impotence and the loss of a sense of identity' (Topor 1997:8) The façade that had covered over the emptiness has collapsed. The qualities/characteristics of being in that place at rock bottom involve hopelessness and a gulf between the role and the individual, which can no longer be bridged.

'I saw everything as completely hopeless I didn't have much faith that I could ever come out of it as a whole person ... but I didn't have any choice either ... Stopping therapy and going back to the way it was before wasn't a real option for me ... so I felt like, all I could do was follow through ... to the bitter end. (M)
(Cited in Topor et al, 1997:10)

At the 'turning point', a number of factors stand out as playing a crucial role. These may take the form of a fortuitous external event or a personal decision. Often the common agent of change is a 'significant other' or 'good persons'. These may be friends, relatives, treatment staff, a particular medicine, a pet or God. These catalysing events come together in the form of an unexpected change in circumstances that force the individual to make a decision.

'I think it was finally getting the right medication that enabled me to find my way out of this. It helped me to start doing things for myself. Because I didn't feel suffocated by the medication, it didn't rob me of my energy I didn't have to be injected, I could take it myself. I was the master over my own medication.'
(Cited in Topor 1997:12)

The most significant element of a 'turning point', which need not be dramatic, is a change in how individuals perceive themselves in relation to their symptoms and condition and their own lives. The goal of regaining one's sense of self is often a slow process and can take a long time. In maintaining the journey of recovery, people emphasise the role their own will, their own efforts, play. Other people are 'conveyors of hope and acceptance'. When they are professionals, they do something more or something different than their professional role requires of them. They break the rules to form a reciprocal relationship. Coincidences play an important role in recovery. It is a journey that cannot be planned, is highly individual and connected to the individual's particular life history.

RECOVERY SKILLS AND SELF CARE STRATEGIES

Research carried out amongst those who live with psychosis without psychiatry reveals that in general self-help begins long before help from others and to a large extent remains effectively independent of it. (Bock 1999) It is not about coping mechanisms in the sense of generalised techniques, but about strategies developed within the context of the individual's complex biography/narrative.

'... from looking carefully at the biographies it is quite clear, that self-help is an immensely complex and very individual process and that the individual protective mechanisms change character in the course of time.'
(Bock 1999:286)

Bock conducted in-depth interviews with 34 people who had persistent and recurring psychotic experiences. The group subdivides into those who previously had no experience of psychiatry and those who had experience of psychiatry or only occasional contact. Using a grounded theory approach, the work seeks to give the psychotic experience an anthropological perspective. Grasping emerging points is like 'a collage'.

'Psychotic experience is recognised as a form of journey of contradiction and social compromise, an ambivalent condition, at the same time incompatibility, finally an illness which contains the seed of health in it.'
(Bock 1999: 15-16)

This experience is not an illness, but may be an existential crisis providing the opportunity or even the function of encompassing a new inner balance. In the process, changes or alterations will be experienced as unburdening or even a loss, but are at the same time sometimes also an expression of erecting a new identity.

Many of the skills required to manage their own lives and their emotional distress can be acquired once people begin to believe in their own capacity to recover, to develop self belief. Self-managed care may include a range of strategies, including holistic remedies, spirituality, physical exercise, creativity and medication. Medication may be a voluntary tool among many used in a personally informed way to assist recovery. The principles of individual choice and self-determination are central to an understanding of what helps people recover.

'I'm on lithium and I should be coming off it next month. I'm trying to go it alone ... My doctor's agreed to let me try it. I lived without it for 35 years. Why should I accept the fact that I have to take lithium for the rest of my life?
(Campbell & Schraiber 1989)

Bock speaks of 'pragmatic defence mechanisms' that help people cope. These may include smoking, play, work or the absence of work, a reduction in stimulation, meditation and creativity. Journaling or keeping a diary may be helpful in making life connections and honouring feelings (Reeves 2000). Creativity helps with expressing feeling, relaxing and being absorbed. Music, pets, gardening and walking in nature also assist recovery (Strategies for Living 2000). Spirituality often plays a role in recovery by providing a meaning or purpose to life, a reason for living, peace and comfort. Recovery itself is a 'spiritual journey - a matter of the heart' (Deegan 1996)

In addition to lifestyle changes, there are many internal changes in awareness of the self that assist recovery. Self-acceptance, accepting one's own humanity and the attainment of peace, play an important role.
(Bock 1999)

'I have to be kinder to myself and not expect miracles. I know its about a process of development which requires time, that every development has its downside and that I have to learn to live with it.'

CAN WE MEASURE RECOVERY?

Since the experience of recovery from mental disorder is such a uniquely

personal and diverse experience we need to approach its measurement with great caution. Who has the right to define recovery as applied to one individual person? What one person may consider to be recovery may not be acceptable to another. The central issue is recognising the importance of the subjective experience of the person rather than applying external professional or societal expectations of recovery to any individual except when behaviour becomes damaging to the individual or society.

Recovery is closely related to the concept of empowerment that grew out of the consumer movements particularly in the USA and Europe. Research studies are few, although some of the research on self-help touches on empowerment. It is a combination of self-determination to gain control over one's life, the creation of an environment in which this can happen and the building of services and policies which support empowerment.

The Well-Being Project (Campbell & Schraiber 1989), a landmark effort conducted by mental health consumers, is a multi-faceted study to define and explore factors promoting or deterring the well-being of persons diagnosed with mental illness in California. Using quantitative survey research, focus groups and oral histories, the research found that nearly 60% of the clients surveyed indicated that they could always, or most of the time, recognise signs or symptoms that they are having psychological problems. The most favoured coping and help-seeking strategies were:

- to write down thought or talk the problem out (50%)
- eat (52%)
- call or see friends (52%)
- relax, meditate, take walks or a hot bath (54%)
- call or go to see a mental health professional (62%)

Attempts to measure recovery are fairly recent and not yet well developed in terms of the exploration of themes and concepts of recovery. Some research and recovery models focus more on outcomes, others on recovery as a process. There is an inherent dilemma/contradiction in attempting to quantify and categorise coping mechanisms whilst at the same time recognising that:

'What in one period of life may be helpful or is at least necessary, can become a hindrance/obstacle'
(Bock 1999)

However, now that 'Recovery Practices' are becoming policy in developing service systems in a significant number of states in the US and nationally in New Zealand www.mhc.govt.nz, the need to measure the effectiveness of these systems and practices requires some means of measuring recovery. Therefore, attempts are being made to develop instrumentation to achieve this and in Ohio in the US, they have built recovery outcomes into their systems wide outcomes measurement system. A Compendium of nineteen Recovery and Recovery-Related Instruments has been brought together under the title 'Can We Measure Recovery?' by Ralph et. Al (2000). The following instruments are three that have been developed and further instruments are currently in development.

Recovery Attitudes Questionnaire developed by a team of mental health consumers, professionals and researchers in Ohio, USA, identified that:

'recovery is possible and needs faith and recovery is difficult and differs among people'
(Ralph et al 2000:8)

Personal Vision of Recovery Questionnaire (PVRQ)(Ensfield, Steffen, Borkin, & Schafer, 1998) was designed to measure consumers' belief about their own recovery. This was developed by a team of consumer and professional researchers. Analysis revealed the five main factors of recovery to be:

1. support
2. personal challenges
3. professional assistance
4. action and help-seeking
5. affirmation

Making Decisions Empowerment Scale (Ralph et al 2000) developed by a group of consumers with consultant researchers revealed five factors relating to empowerment and recovery:

1. self efficacy/self-esteem
2. power - powerlessness
3. community activism
4. righteous anger
5. optimism, control over the future

Other measurement instruments concluded that quality of life and independent social functioning are most likely to be related to personal empowerment while organisational empowerment is more related to involvement in work, both paid and volunteer.

The Recovery Advisory Group (www.mhsip.org/recovery) Model of Recovery focuses both on external influences of recovery and the internal, individual recovery process. It is a reflection of consumer survivor published and unpublished literature and the personal experiences of members of the Advisory Group. It recognises that the achievement of well-being or wholeness is not linear but is a process of stages that go toward well-being. These stages are:

Anguish,
Awakening,
Insight,
Action Plan,
Determined Commitment to become well
Well-being/Empowerment

All stages may not be experienced by everyone, nor does a person complete one stage before going to another. Recovery is viewed as both internal and external. Internal aspects of recovery include: cognitive, emotional, spiritual and physical. The external dimensions consist of a person's action and reaction to external influences or interactions with people and situations as they move across, round and through stages of recovery. The internal journey continues within the context of the external world and its influences.

Recovery is unique to each individual and therefore it is essential to remember this when attempting to measure people's experiences. The centrality of experience is so important that involving people with similar experiences is essential to informed data collection and instrument development.

IMPLICATIONS FOR PRACTICE AND POLICY

Research has shown that for the majority of people, relationships with

professionals and mental health service delivery is key to recovery. Where this is positive, it allows the development of people's dreams and goals for recovery.

'It came through that she wasn't just in it for the money or you know she wasn't up herself, I'm the psychiatrist, you're the patient sort of thing. She treated me like an equal person and just, I always saw her true person coming through sort of thing.
(Tooth et al. 1997)

Deegan (1996) and Glover (1999) both emphasise the importance of hope. This requires mental health professionals to appreciate:
'the deep existential struggle that the person in despair is living through.' (Deegan 1996)

Barker, a professor of psychiatric nursing, with experience as a psychiatric nurse and academic, has developed a conceptual model for the development of acute services entitled 'The Tidal Model. (Cowan 1999:18) The person is the story and their environment is likened to the ocean. It may be calm or stormy. There may be rocks or lighthouses. The purpose of professional intervention is to help the person concerned to understand their own story and to assist the person to change the direction the story is taking.

Saleeby (1992), a social worker, developed an Ecology Model, drawn from the biological sciences, emphasising the need for a healthy environment for organisms to develop well. This was further developed at Kansas University and is variously known as the Kansas or Strengths Model (Rapp 1998). It demands from mental health workers a conceptual leap to stop assessing for and identifying problems, deficits, sickness or being unwell.

'It demands that the created environments for people with severe and persistent mental illness are overtly enabling rather than entrapping.'
(Cowan 1999)

Changing mental health services will require that they be founded on 'recovery based competences' (New Zealand Mental Health Commission 2000 - They would not be an add-on to current training, but would require a fundamental change in training. In New Zealand a list of competencies has been developed by service users drawing on a range of information sources. They focus among others on understanding recovery principles and experiences, equality and social inclusion, recognising self-determination, acknowledging and supporting the service user movement and family support.

In addition to the training of professionals, gaps in service provision have been identified in the UK. These include more easily accessible services in a crisis, particularly out of office hours and emergency care overnight, more talking and complementary therapies and a greater awareness of the diverse needs of people from minority ethnic communities (Mental Health Foundation, 2000).

Weaver (1998) states:

"As a provider here's what you might need to think in order to assist a consumer with recovery:

1. I will stop trying to control the consumer's life
2. My professional success is based on the consumer's recovery progress
3. I listen to, believe, and value what the consumer says
4. I will not treat a consumer any different than anyone else
5. I have in-depth knowledge about and sympathy for the consumer's

- disability
6. I will not allow a consumer to become overly dependent upon me
 7. I can give a consumer hope or helplessness - it is my choice
 8. I see potential in the consumer
 9. I serve as a "coach" not as an authoritative mental health professional
 10. I will not become discouraged when a consumer fails or rejected when a consumer succeeds
 11. I will take care of my whole being - dealing truthfully and realistically with the spiritual mental, emotional, and physical aspects of my life."

The consumer group in Ohio mentioned earlier developed a set of statements to rate the impact of mental health professionals on their recovery. In a pilot study, clients in the mental health system rated these from most to least impact like this.

1. Encourage my independent thinking
2. Treat me in a way that helps my recovery process
3. Treat me as an equal in planning my services
4. Give me freedom to make my own mistakes
5. Treat me like they believe I can shape my own future
6. Listen to me and believe what I say
7. Look at and recognize my abilities
8. Work with me to find the resources or services I need
9. Are available to talk to me when I need to talk to someone
10. Teach me about the medications I am taking.

Key issues identified in consumer personal accounts are validations of these, for example, encouragement, belief in abilities, empowerment (e.g. treating as equal in planning for and delivery of services), listening and believing, and free choice.

IMPLEMENTING RECOVERY ORIENTED PRACTICE

There are a number of developing approaches to implementing recovery oriented practice with the largest scale implementation being the Ohio Consumer Outcomes Initiative (www.mh.state.oh.us/initiatives/outcomes/outcomes.html) in which they have built recovery into their information technology based outcomes system that functions from individual case management and enables the aggregation of information at a state level.

Perhaps the fastest growing individual approach to mental health recovery is the self-management framework developed by Mary Ellen Copeland in Vermont, USA (www.mentalhealthrecovery.com). The Wellness Recovery Action Plan (WRAP) is a simple yet powerful self-help system based on increasing awareness, improving self-care and strengthening supports. The following is a brief outline of the framework:

Five foundations of recovery

Hope, Personal Responsibility, Education, Self-Advocacy, and, Developing & Maintaining a Support System.

Wellness Tools

Activities, routines, thoughts & behaviours that maximise wellness and minimise symptoms include: reaching out for support, peer counselling, maintaining an ongoing dialogue with health and social care professionals, planning the day, stress reduction and relaxation techniques, focusing exercises, diversionary activities & fun, journaling, exercise, sleep, being outside, increasing or decreasing stimulation, and the act of

stopping to analyse the situation to make a thoughtful decision on how to proceed.

Writing a Plan

Writing a plan must be entirely under the control of the individual who plans to use it, when they are well or feeling alright and with help from their supporters if they wish. Mental health staff, family members and friends can provide support, feedback and encouragement. The process can be lengthy and must be done at the individual's own pace.

Sections of the Plan

1. Daily Maintenance -- What I do each day, when I am feeling well.
2. Triggers - What are my triggers & what is my response to each one.
3. Early Warning Signs - What are early warning signs for me, and what is my action plan for each one.
4. When Things are Breaking Down - How do I know? Breaking down list and responses / action plan.
5. Crisis Plan - How to know when I am well, crisis symptoms, supporters phone list, medications, treatments, treatment facilities & respite care, supporters' roles, what to do if I am a danger to myself or others, and how to know when my supporters no longer need to use this plan.

Self-management of mental health issues and wellness are an essential component of recovery-oriented services.

"Patients can only be fully involved in their treatment if they have the requisite knowledge and skills. And if the health professionals who treat them recognise those skills and knowledge, working in partnership to devise and implement individual pathways of care."
Department of Health (September 2001)

Self-management began in the 1970's for people with chronic physical conditions in the US but not until the late 1980's and early 1990's with regard to people who experience mental health problems. Development and evaluation of self-management is in its early stages in the UK where it has arisen out of the July 1999 White Paper, Saving Lives: Our Healthier Nation and the NHS Plan in July 2000 that set out the Government's vision for a new, more patient-centred NHS and confirmed a commitment to help people with long-term conditions maintain their health and improve their quality of life through an Expert Patients Programme.

There are a number of self-management information resources and tools now available in the UK that include: Wellness Recovery Action Planning, the Manic Depression Fellowship Self-Management Training Programme and self-management books and resources for people who hear voices and self-harm (Working with Voices and Working with Self-harm, Handsell Publishing). There are also a number of developing service-user run crisis and recovery support services that operate in 'recovery' oriented ways that recognise the importance of self-management (e.g. CHANGE see www.mentalhealthrecovery.org.uk).

The authors believe from their knowledge of the research outlined in this paper and elsewhere, on recovery from 'mental disorder', that if our services recognise the importance of self-management as an adjunct to other mental health treatment approaches, and provide hope for recovery to its service users, then the effectiveness of services will be significantly increased.

"The challenge for the NHS, working in partnership with patient organisations and other governmental departments... is to bring about a fundamental shift in the way in which chronic diseases and long-term conditions are managed - a shift which will empower and liberate patients to play a central role in decisions about their illness."

CONCLUSION

It is clear that the recovery movement being led by people with experiences of mental disorder and their family members can make a very positive contribution to the effectiveness of the services being delivered. It therefore highlights the need for the investment of resources to carry out research into what helps people's recovery from mental disorder, including self-management, in order to begin delivering the most effective recovery oriented services as part of the development of services within the current policies being implemented nationally in England.

However, the innate tension that exists within the concept of recovery from mental disorder is not easily resolved. It is both a process and an outcome, it may be measurable and it is immeasurable. The research reviewed demonstrates the paradox. It will take time and patience, amidst the confusion, to persevere with research into recovery and learn from the personal knowledge gained through the uniqueness of peoples own struggles with their experiences and discoveries of effective coping mechanisms and strategies for wellness. We should take comfort in knowing that emergent paradigms are always like this. For our service systems we must recognise that:

"Recovery requires the right atmosphere or organizational climate in your mental health organization - one that is sensitive to consumers, and values independence of the individual. It allows consumers to risk, to fail. It holds that every consumer has a right to the same pleasures, passions, and pursuits of happiness that we have. It looks at potential, not deficits."

Weaver (1998)

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This literature review has been completed by the Centre for Community Mental Health at the University of Central England in Birmingham as part of the social inclusion project of the West Midlands Partnerships for Mental Health. The creation of the Centre is primarily aimed at providing a vehicle for the involvement of local expertise alongside our wider network of national and international expertise to help deliver a new paradigm in mental health care; generating, disseminating and supporting best practice, both at an organisational and individual level. Central to the work of the Centre is a belief that recovery is possible for everyone with diagnoses of serious mental illness and that in order to deliver recovery-oriented services, the involvement of people with lived experiences of mental distress are critical at every level of service planning, delivery and evaluation.

The CMHP is based within the Faculty of Health and Community Care, Butler Building, Westbourne Road, Edgbaston, Birmingham B15 3TN Tel 0121 331 7111 Fax 0121 331 7168 and email ccmh@uce.ac.uk and www.ccmh.uce.ac.uk

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