Advances in Psychiatric Treatment (2007), vol. 13, 397–399 doi: 10.1192/apt.bp.107.004101

Editorial

Recovery: our common purpose?

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Abstract The Royal College of Psychiatrists' Annual General Meeting in Edinburgh in June 2007 witnessed the launch of the joint position statement from the College, the Care Services Improvement Partnership and the Social Care Institute for Excellence 'A Common Purpose: Recovery in Future Mental Health Services' as part of its opening session. This is now available as a stimulus and a guide for clinicians and teams to consider how to engage in the recovery agenda and whether to make it their common purpose also.

It seems hard to disagree with the proposition that recovery should be the guiding purpose for future mental health services. For what are we and our services doing if we are not supporting individuals and families in a process of personal recovery? It is equally clear that by no means everyone is comfortable with embracing the 'recovery agenda', and professionals, service users and carers alike have expressed reservations that need to be carefully considered.

Where personal or professional experience has been of suffering, disability and sometimes tragedy despite the best treatment, discussion of recovery, which pivots on cultivating and sustaining hope, can seem a bit empty and denying the reality of severe mental disorder. In such circumstances this optimistic concept can be provocative to experienced clinicians, service users and families alike. Carers and professionals have raised concerns that emphasising recovery for people with persisting symptoms and long-term conditions amounts to a denial of disability and a distortion of meaning.

Some in the service user movement worry that professional interest will amount to a self-promoting process of co-opting or colonising something that belongs to them, and dislocate the recovery movement from its origins in civil rights and disabilities movements (Davidson *et al*, 2006; Glover, 2007).

Some cynics take a darker view and worry that endorsement of recovery and self-management by governmental and corporate interests will be misused as justification for cutting services.

But an emphasis on personal recovery is a broader consideration than looking for favourable changes in clinical parameters such as reduced symptoms and use of services, and is emphatically not about reducing resources so much as mobilising resourcefulness.

A personal journey

The current interest in recovery has grown out of testimony from service users who have survived complex and adverse experiences and whose hope, resilience and capacity to live, and live well, even in the context of ongoing difficulties, offer an example and inspiration to others.

A recovery emphasis for services asks whether it is possible for an individual's life story and personal values to be supported in such a way that their own resilience is strengthened. It asks for that which is personally meaningful and individually significant to be valued, understood and given priority. It considers culture, diversity, spirituality and sexuality as not just a matter of equality but as a resource that can support personal recovery.

Accounts by people in recovery of what matters most to them can present mental health professionals with an uncomfortable confrontation with our limitations and the narrowness of our vision. Spirituality, peer support, self-management, creativity and the arts, satisfactory housing and finances and work, gardening, pets and hobbies

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all figure highly in stories of personal recovery (Leibrich, 1999) and yet are virtually absent from our textbooks and guidelines.

This is why recovery has to be individual. It cannot be prescribed. It is not what we do to others. Recovery is not a treatment, although it may well be supported by the careful deployment of evidence-based approaches. Its meaning has to be found and nurtured by individuals and families. If we are going to be more interested in supporting people in recovery and in their social inclusion than in treating them, we will need to widen our vision to include an intimate and growing understanding of the lived experience of mental disorder and how people have overcome its limitations.

Relinquishing control

People cannot progress in recovery while others are in control of their lives, so clinicians may need to think how to 'let go' a bit. We may need to share authority and power, have a greater openness to what patients say and wish, and be more trusting and supportive of their personal priorities. Recovery-oriented services will see a shift in our role towards becoming coach, mentor, educator and facilitator. An individual's confidence in their recovery may come and go, especially at the beginning of their journey and at times of setback and adversity, but is powerfully supported by the example of peers and the hope of those around them who convey a sense of believing in them. On this basis we have confidence that recovery is open to all.

Similar ideas and agendas emphasising choice and self-determination are simultaneously being developed for other patient groups, including people with chronic neurological and other long-term conditions (Department of Health, 2005, 2006, 2007). These clinical and policy initiatives are all in support of a movement to equip clinicians and service users for a future form of recovery-oriented practice in which therapeutic relationships are built on collaboration and partnership, sharing responsibility for both treatment decisions and outcomes. There is broad agreement that we will need to develop our skills in supporting self-care, self-management and self-directed care, and this emphasis is finding its way into the core curriculum and competency-based training agenda for psychiatrists. The biggest challenge will be in developing recovery-based practice in circumstances of custody or severe disability, where there is the greatest likelihood of institutionalisation and attendant loss of hope and there is an associated need to give thought to the relationship between recovery and compulsion or coercion.

Recovery in *APT*

The initiative begun at this year's annual meeting of the Royal College of Psychiatrists (Royal College of Psychiatrists *et al*, 2007), with recovery as its overarching theme, will be extended in future issues of *APT*, which will offer a continuing opportunity for reflection and debate through a series of articles on aspects of recovery and recovery-based practice. If you are already an enthusiast there will be much to stimulate further thought and action; if you remain cautious or sceptical, you are clearly not alone and you will be presented with a succession of invitations to engage with and contribute to the recovery debate. An emphasis on recovery is of no value if it is not authentic and both clinically and intellectually robust: doubt and debate are essential elements of a healthy developmental process.

Louis Appleby, the National Director for Mental Health for England, in welcoming a recent joint position paper on recovery in mental health services (Care Services Improvement Partnership *et al*, 2007) stated that 'recovery now sits beside choice, independence and inclusion as the watchwords of modern mental health care' (Royal College of Psychiatrists *et al*, 2007). These values and aspirations are broadly applicable and at the heart of innovative and progressive approaches across health and social care. For example, the White Paper *Valuing People* (Department of Health, 2001) was based on recognition of the rights of people with learning disabilities as citizens, the importance of their social inclusion in local communities, choice in their daily lives and real opportunities to be independent. *Valuing People* was developed in collaboration with people with learning disabilities and it has had considerable impact on their own aspirations to live full lives despite having a long-term condition, as well as on the thinking of service providers.

We have both enjoyed learning about the meaning of recovery from our patients, families and friends, and consider that we have a great deal more to learn about recovery and hope in the lives of people with serious mental illnesses and other disabling conditions.

As good scientists we are concerned for the need for evidence and that rhetoric is underpinned by reality. As good clinicians we are aware of the need to make use of the evidence in the context of the values and circumstances of individuals. Our reading of 'recovery' is that it is hospitable to this simultaneous need for rigour and richness, validity and individuality, and we invite you to take a look for yourself.

And finally, it is a key 'recovery competency' for practitioners to become skilled in sustaining their own hope and morale, so a shift towards a recovery

https://doi.org/10.1192/apt.bp.107.004101 Published online by Cambridge University Press

emphasis could be good for both us and our teams, as well as for our patients. If an emphasis on recovery proves its worth then it could become securely adopted as the guiding purpose for our services, with the hope that it becomes the increasingly common experience for both those who practise and those who receive mental health services.

Declaration of interest

None.

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https://doi.org/10.1192/apt.bp.107.004101 Published online by Cambridge University Press