Box 15.1 The four critical recovery values of the Center for Psychiatric Rehabilitation

1. **Person orientation**
   The service focuses on the individual first and foremost as an individual with strengths, talents, interests as well as limitations, rather than focusing on the person as a 'case', exhibiting indicators of disease
2. **Person involvement**
   The service focuses on people's rights to full partnership in all aspects of their recovery, including partnership in designing, planning, implementing and evaluating the service that supports their recovery
3. **Self-determination/choice**
   The service focuses on people's right to make individual decisions or choice about all aspects of their own recovery process, including areas such as the desired goals and outcomes, preferred services used to achieve the outcomes, preferred moments to engage or disengage in services
4. **Growth potential**
   The service focuses on the inherent capacity of any individual to recover, regardless of whether at the moment he or she is overwhelmed by the disability, struggling, living with or living beyond the disability

which is of little relevance to front-line staff, and to which they often have minimal sense of connection.

What are the guiding values of a recovery-focussed mental health service? They don't have to be complex. Bill Anthony has proposed the transcendent principle of personhood[453]:

People with severe mental illnesses are people
(p. 205)

This provides a fundamental orientation for mental health services. People with mental illness want to work, love, play, make choices, be citizens – all the normal entitlements, roles and responsibilities of being a person. The task of mental health services is to support progress towards these goals.

This single principle is a helpful summary for those staff who easily connect with recovery values, but many professionals will find a slightly expanded approach more helpful. At the Center for Psychiatric Rehabilitation (CPS) at Boston University (www.bu.edu/cpr), four recovery values are identified[454], which underpin their approach to promoting well-being described later in Case study 17. These are shown in Box 15.1.

These four values have profound implications for how the service works[455;456]. Person orientation means the service promotes access to resources outside the mental health system where meaningful, socially valued roles can be attained, rather than limiting people to mental health ghettoes. Person involvement means 'nothing about us without us': meaningful involvement of consumers at all levels of the system, including designing and delivering services. Self-determination/choice involves the opportunity to choose one's own long-term goals, rather than experiencing coercion which has the effect of diminishing rather than strengthening the self[121]. So, for example, it means that a student's choice to give up a new work role because 'the other people didn't like me' is validated rather than pathologised. This doesn't preclude discussion about what happened, consequences, costs, benefits and learning points, but the choice itself is supported. Finally, growth potential means a commitment to creating and maintaining hopefulness in people using and working in services, through selection, training, supervision and programme development processes.

Box 15.2 Recovery values at the MHA Village

1. **Client choice**: a menu approach is used to provide services based on the individual's own goals
2. **Quality of life**: the services focus on areas that address all parts of individuals' lives (e.g. work, education, finance, social goals)
3. **Community focus**: living, learning and working should be done through integration rather than segregation
4. **Whatever it takes**: services are available on a continuous basis, and follow a 'no-fail' approach – individuals are not transferred out because of the challenges they pose

---

Box 15.3 Ten recovery principles of the Yale Program for Recovery and Community Health

1. Care is recovery-oriented
2. Care is strengths-based
3. Care is community-focussed
4. Care is person-centred
5. Care allows for reciprocity in relationships
6. Care is culturally responsive
7. Care is grounded in the person's life context
8. Care is relationally mediated
9. Care optimises natural supports
10. It (really) is your job

As an alternative, some of the recovery-promoting values used at the MHA Village (www.village-isa.org) are shown in Box 15.2.

Again, the impact of working in accordance with these values is profound. Client choice means that the response to a client who does not take up an intervention may be to identify the need to develop new menu items (i.e. support and intervention approaches), rather than labelling the client as non-compliant. Quality of life means that staff supported someone who wanted a sexual relationship to use a dating service. Community focus means that real-life work expectations are placed on individuals, as outlined later in Case study 18.

The Yale Program for Recovery and Community Health (www.yale.edu/prch) has published ten principles for recovery-oriented community-based care[404], shown in Box 15.3.

Their last principle addresses their experience that many clinicians, even when stating agreement with all the previous principles, do not change their own practice.

My own suggested core values for a recovery-focussed mental health service are shown in Box 15.4.

These values point to the need for a new balance, with less responsibility for and more responsibility with the person. Taking responsibility for the person outside situations of crisis atrophies the person's knowledge of being responsible for their own life, and reduces their capacity to take personal responsibility and self-manage. Taking responsibility with the person means explicitly negotiating and collaborating within a partnership relationship, holding a rapidly reducing share of responsibility as the clinical focus moves as soon as possible from doing to (during crisis), through doing with, to the person doing for themselves. It also involves values-awareness by the clinician – a self-knowledge about personal and clinical values.

The second process is to **embed values into the daily life and working practices of the mental health system**. This is a major challenge, since training in values does not easily

> **Box 15.4** Proposed values for a recovery-focussed mental health service
>
> **Value 1: the primary goal of mental health services is to support personal recovery**
> Based on the five rationales presented in Chapters 4 to 8, supporting personal recovery is the first and main goal of mental health services. Treatment goals are important but secondary.
>
> **Value 2: actions by mental health professionals will primarily focus on identifying, elaborating and supporting work towards the person's goals**
> If people are to be responsible for their own life, then supporting this process means avoiding the imposition of clinical meanings and assumptions about what matters, and instead focussing on the person's life goals.
>
> **Value 3: mental health services work as if people are, or (when in crisis) will be, responsible for their own lives**
> It is not the job of mental health professionals to fix people, or lead them to recovery. The primary job is to support people to develop and use self-management skills in their own life. The instinctive response of clinicians to any situation needs to be '*You can do it, we can help*':
> - *You can do it* because of a genuine belief in the immense potential for self-righting and taking personal responsibility within each person and their wider community
> - *We can help* because of a simultaneous belief that professional training has high value for many people, especially when Value 2 is followed

impact on practice[309]. It involves both bottom-up and top-down ownership, and requires skilled leadership and system transformation. People working in recovery-focussed services need to know and own the organisational values around recovery, have the ability to link values with behaviour, and feel empowered to address discordance. In Chapter 13 we explored how values impact on the relationship between professionals and consumers, and identified the need for changes to the social construction of a professional relationship. Later in this chapter we will outline the contribution of values-based practice to recovery.

The third process involves **tailoring practice through performance feedback**. Without good information about success, the natural tendency is to assume all is well (or, at least, to focus attention on the many other pressing demands). For example, working practices at the CPR (whose values were outlined in Box 15.1) are tailored using the Stop – Start – Continue approach: using evaluation data to identify what needs to stop, to start or to continue to amplify the presence of the intended values in the organisation. In their education program (described in Case study 17), evaluation showed a slow throughput of clients. This led to a questioning of whether the service was fully supporting the value of each person having growth potential to reclaim valued social roles. As a result, they re-oriented their programmes towards a greater location in the community, with more opportunities for community participation.

As another example, UK training in Wellness Recovery Action Planning (WRAP)[351] has evolved using feedback from participants about the presence of specific values in the training, including:

> Self-determination, personal responsibility, empowerment and self-agency are key aspects of these sessions
>
> All 'peers' are treated as equals with dignity, compassion, mutual respect and unconditional high regard
>
> Sessions are based on the premise there are 'no limits' to Recovery
>
> It is understood that each person is the expert on her or himself

Clinical reality can make it difficult to follow values. Sometimes people say they want things which are hard to understand or even seem harmful, or they say they want no help even though their lives seem, to the observer, highly impoverished. The challenge is developing approaches to responding which are concordant with explicitly stated values. There is much existing expertise in the mental health system to build on. We now identify some established clinical approaches which can contribute to a recovery focus.

Evidence-based practice as a contributor to recovery

The development of evidence-based practice (EBP) is to be welcomed. The systematic evaluation of interventions before their widespread introduction will reduce the likelihood of damaging practices such as those outlined in Chapter 7. The development and dissemination of clinical guidelines[142;165] to increase consistency and quality of treatment is a key achievement of mental health services in the twentieth century. Clinical practice should always be informed by this knowledge base.

However, the limitations of EBP are also important to understand. This relates to the limitations of nomothetic knowledge, outlined in Chapter 4. For example, Whitwell highlights the changing nature of what is seen as effective, with each generation of clinicians believing that their approaches, unlike previous treatment regimes, are scientific and evidence-based[22]. He raises the null hypothesis issue – that no specific treatments are effective, and concludes that in fact each new treatment only has an effect due to nonspecific factors such as positive expectations, contact with a support system, positive human values, support with basic necessities, human contact and restoration of physical health. Whilst admiring the modesty involved in this stance, this view goes too far. Treatments are effective, for some people, some of the time.

The central limitation of EBP is the tendency to reduce rather than amplify meaning. The more central EBP becomes, the more decontextualised, objectified and divested of meaning the patient becomes. So whilst EBP has an important contribution, in a recovery-focussed service it is a tool rather than a clinical imperative. As Whitwell comments[22], EBP supporters:

> see it as a way of cleansing medicine from messy subjectivism. Its advocates use the results to produce protocols for treatment – so that decisions made will conform to 'best practice'. This however is only a short distance away from the old ideas of compliance – except now not only should the patient comply, but also the doctor.
>
> (p. 131)

Working to support recovery means that the expert clinician offers knowledge about best available evidence for treatments as a resource within a partnership relationship. In general (with exceptions discussed in Chapters 20 and 21), trying to convince the patient they need clinician-specified treatment or imposing treatments in the patient's best interest is a sign that the professional is getting in the way of the person's recovery. Forced treatment is oxymoronic, and doing things to the patient is more likely to promote passivity, dependency and other anti-recovery effects.

One antidote to the EBP tendency to remove meaning is offered by narrative-based medicine.

Narrative-based practice as a contributor to recovery

An approach to blending group-level nomothetic knowledge and patient-level idiographic knowledge is found in narrative-based medicine, in which the aim of listening is to understand what the patient is saying[457]:

> Even the most pompous professors have been known to warn their students, 'Listen to the patient: he or she is telling you the diagnosis'. A more sophisticated view holds that when doctors take a medical history they inevitably act as ethnographers, historians, and biographers, required to understand aspects of personhood, personality, social and psychological functioning, and biological and physical phenomena.
>
> (p. 49)

Narrative-based medicine highlights the role of literature in giving insights into the human condition[458], and can act as a balance to the reductionism of evidence-based medicine[459]:

> Narrative is endemic to medicine, but has been excluded in the rise of EBM (evidence-based medicine). It remains to be seen whether narrative's ecumenicalism will be rebuffed or reconciled with EBM's fundamentalism, but there are signs of convergence. . . . There is an emerging image of the mature and experienced clinician of the future, who will have the capacity to integrate narrative- and evidence-based perspectives, quantitative and qualitative methods, and have a balanced awareness of the contributions and limitations of both as a sound basis for clinical judgements.

Narrative is important. Comparing self-reported and clinical accounts of an experience indicates the profound difference between clinical and subjective perspectives[4;110]. For example, Mary O'Hagan wrote[122]:

> Today I wanted to die. Everything was hurting. My body was screaming. I saw the doctor. I said nothing. Now I feel terrible. Nothing seems good and nothing good seems possible.
>
> I am stuck in this twilight mood
> Where I go down
> Into a lonely black hole
> Where there is room for only one.

Her contemporaneous admission file recorded: 'Flat. Lacking in motivation, sleep and appetite good. Discussed aetiology. Cont. LiCarb 250mg qid. Levels next time.'

Lodge differentiates between the use of science to uncover generalisable insights and laws, and the use of literature to describe the 'dense specificity of personal experience'[460]. As Whitwell puts it[22]: 'narrative is not some second-rate homely account, to be disregarded once science has caught up. It is the closest we can come to the unknowable reality of the experience of other people' (p. 59). Understanding is a matter of narrative, and the application of scientific treatments needs to be consistent with the patient's narrative. This integration provides a vehicle for placing the patient's meaning centre-stage. Why should we want to do this? The answer is a matter of values.

Values-based practice as a contributor to recovery

A third established approach is values-based practice – the theory and skills base for effective health care decision-making where different (and hence potentially conflicting) values are in play[309]. Ten pointers to good process in values-based practice, developed by Bill Fulford[309] and with names suggested by Glenn Roberts[461], are shown in Table 15.1.

Values-based practice highlights that the application of technology (e.g. assessment processes, treatments, outcome evaluation) is not a neutral activity. Awareness of and debate about implicit values is as important as discussion about the optimal treatment strategy. It points to the primacy of the patient's values, the importance and limitations of evidence-based practice, and the centrality of language, communication and negotiation.

Table 15.1 Ten principles of values-based practice

Principle name	Description
The 'Two feet' principle	All decisions are based on values *and* facts, including decisions about diagnosis
The 'Squeaky wheel' principle	We tend to notice values only when they are diverse or conflicting and likely to be problematic
The 'Science-driven' principle	Increasing scientific knowledge creates choices, which brings the full diversity of human values into play
The 'Patient-perspective' principle	The first source of values information is the perspective of the patient
The 'Multi-perspective' principle	Conflicts of values are resolved by balancing legitimately different perspectives, not by reference to a predefined rule
The 'Values-blindness' principle	Careful attention to language use raises awareness of values
The 'Values-myopia' principle	First-hand narratives, survey, media and social science reports can all improve our knowledge of other people's values
The 'Space of values' principle	Ethical reasoning is employed to explore differences of values, not to determine 'what is right'
The 'How it's done' principle	Communication skills are central to conflict resolution and clinical decision-making
The 'Who decides' principle	Decisions are taken by patients and professionals in partnership

A mental health service using a values-based practice approach necessarily places great emphasis on the dreams, aspirations and goals of the person. This approach therefore promotes a focus on personal recovery.

Perhaps the most developed approach to working in a pro-recovery way has emerged from the rehabilitation part of the mental health system.

Rehabilitation as a contributor to recovery

Rehabilitation services work longer-term with people who have severe and enduring mental illness. There is a difference between rehabilitation and recovery[462]:

> Rehabilitation refers to the services and technologies that are made available to disabled persons so that they may learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability.

Rehabilitation services are concerned with bridging the gap between an individual and their aspirations, through effective treatments, skills training and practical and emotional support. These are key pro-recovery skills, which perhaps accounts for the close alignment between rehabilitation and recovery[463]. See for example uspra.org. However, not all rehabilitation values support recovery. This is evident in the best current text-book on rehabilitation psychiatry[21]. On the one hand, the rhetoric is highly pro-recovery:

> The central ambitions of contemporary rehabilitation services are to rekindle hope and to open routes to personal recovery, while accepting and accounting for continuing difficulty and disability. Best practice pivots on a mature and creative

balance of optimism and realism, and requires the ability to tolerate protracted uncertainty and remain curious and hopeful.

(p. xv)

On the other, traditional assumptions leak in:

In truth, many if not all people with psychotic and other severe mental illnesses do have 'long-term conditions' for which long-term thinking and strategies are appropriate.

(p. xvii)

Table 15.2 Differences between traditional and recovery-focussed services

Traditional approach	Recovery approach
Values and power arrangements	
(Apparently) value-free	Value-centred
Professional accountability	Personal responsibility
Control-oriented	Oriented to choice
Power over people	Awakens people's power
Basic concepts	
Scientific	Humanistic
Pathography	Biography
Psychopathology	Distressing experience
Diagnosis	Personal meaning
Treatment	Growth and discovery
Doctors and patients	Experts by training and experts by experience
Knowledge base	
Randomised controlled trials	Guiding narratives
Systematic reviews	Modelled on heroes
Decontextualised	Within a social context
Working practices	
Recognition	Understanding
Focus on the disorder	Focus on the person
Illness-based	Strengths-based
Based on reducing adverse events	Based on hopes and dreams
Individual adapts to the programme	Provider adapts to the individual
Rewards passivity and compliance	Fosters empowerment
Expert care co-ordinators	Self-management
Goals of the service	
Anti-disease	Pro-health
Bringing under control	Self-control
Compliance	Choice
Return to normal	Transformation

> We were not able to recruit as broad a contribution as we would have wished from
> service users to give a view about user-led services. At present we can look in vain for a
> mental health equivalent of the League of Friends[a] that characterises patient
> involvement in general hospital.

(p. xix)

> This then raises such familiar, mundane but essential issues such as how to get
> someone out of bed, how to get day and night in their proper places, how to ensure
> that the person is dressed appropriately, has adequate personal hygiene and is taking
> necessary medication.

(p. xx)

Assumptions of chronicity, acceptable types of user involvement and doing-to may be deeply entrenched views within rehabilitation services: values which will need to change if rehabilitation approaches are to fully support recovery. A key challenge to mental health practitioners will be to provide best possible recovery-oriented rehabilitation services, whilst simultaneously recognising that, for some people, their journey to recovery is primarily or exclusively outside mental health services.

British readers will be familiar with the saying *Don't throw the baby out with the bath-water*, meaning that it is important during any change process to identify what to keep, as well as what to let go of. Whenever calling for change, it is easy to denigrate the old and idealise the new. This is not the intention in this book. Traditional mental health services have developed much expertise which supports personal recovery. We have identified four existing approaches which should feature prominently in any pro-recovery mental health service: evidence-based practice, narrative-based practice, values-based practice and rehabilitation. We now turn to the bath-water aspects: the points of difference.

Differences between traditional and recovery-focussed services

The central differences between a recovery-focussed approach and traditional clinical practice have been considered by several authors with experience of trying to implement pro-recovery change[143;464–467]. In Table 15.2 we summarise some points of variation.

Table 15.2 provides a summary of some key differences, and is consistent with the Personal Recovery Framework of Chapter 9. We now make the summary more concrete, by outlining how recovery-focussed services work in practice. We start with assessment.

---

[a]A voluntary organisation in UK general hospitals, typically staffed by ex-patients and informal carers, which fund-raises and provides practical support to patients – but as an adjunct to the clinical services rather than as a peer-led service

Assessment

How can assessment promote recovery? In Chapter 13 we described partnership relationships, and distinguished them from detached relationships. In a partnership relationship there are two experts in the room, and the process is characterised by two-way conversation rather than one-way examination. We turn now to the content of this conversation.

The aims of assessment differ from the traditional clinical goal of identifying the illness and planning the treatment. Aims of a recovery-focussed assessment include:

1. To promote and validate the development of personal meaning
2. To amplify strengths rather than deficits
3. To foster personal responsibility rather than passive compliance
4. To support the development of a positive identity rather than an illness identity
5. To develop hopefulness rather than hopelessness.

In considering how assessment can meet these aims, the intention is not to provide a comprehensive how-to-assess guide. Rather, the goal is to provide resources and pointers to good practice which can be integrated, in different ways, into the work of individual clinicians.

Using assessment to develop and validate personal meaning

The development of personal meaning is central to recovery, but 'most people find little in the way of meaning or purpose in fulfilling the role of mental patient'[330] (p. 156). How can clinicians assess the person in a way that avoids imposing meaning and hence getting in the way of recovery?

In the Personal Recovery Framework presented in Chapter 9, we identified the central distinction between the person experiencing the mental illness and the mental illness itself, and the consequent importance of a primary focus on the person, not the illness. Consistent with this stance, our first consideration of meaning should be at the level of the person, and their search for a meaningful life. Can we define the ubiquitous term meaning of life? A conceptual framework is provided by Baumeister[468], who differentiated between four needs for meaning. These are shown in Table 16.1, along with their implications for clinical practice.

This framework is not specific to people with mental illness – it applies to anyone. All four needs for meaning are important. The meaning of life is normally not singular, but emerges from a constellation of domains including family, love, work, spirituality and personal projects[469]. Multiple sources of meaning are also buffers, reducing the impact of losing one source and relieving the pressure on any individual domain to satisfy all four needs for meaning[447].

Reflective practice is relevant to the assessment process, because assessment is action: in a socially constructed world, questions shape the emergent meaning. Applying this framework

Table 16.1 Four needs for meaning

Type of meaning	Definition	Implication for working practices in mental health services
1. Purpose	Present events draw meaning from their connection with future events	Listen for personal meaning and meaning-making approaches in accounts of past and current events
Two types:		
(i) Goals	An objective outcome, such as job promotion, having a child	Identify personal goals, provide goal-setting and goal-striving support. Facilitate access to mainstream opportunities (employment, education, leisure, social)
(ii) Fulfilments	A subjective anticipated state of future fulfilment, such as being in love, going to Heaven	Encourage optimism and hopefulness. Ask future-oriented questions – 'Where would you like to be in 5 years?', 'How can I support you to work towards that dream?'
2. Values	Lends a sense of goodness or positivity to life, can justify certain courses of action	Support spiritual development by facilitating access to religious, faith, humanist, cultural or political groups. Avoid undermining the individual's values by imposing personal or professional values (e.g. a clinical model, the importance of empiricism, societal norms)
3. Efficacy	A belief one can make a difference	Identify and amplify times of well-being, when person showed mastery and coped with unanticipated difficulties. Plan ahead. Identify personal and social resources. Support the development of crisis plans
4. Self-worth	Reasons for believing one is a good, worthy person	Actively encourage the person to take on 'giving back' roles – voluntary work, co-running a group, writing about their experiences, becoming a peer mentor. Foster affiliation with high-status groups (especially outside the mental health system)

in a mental illness context orients the clinician towards key reflective practice questions. Do I know this person as s/he sees her/himself? Do I know what is meaningful to this person? Am I working to support the person to transcend their illness experience, to meet personal goals and fulfilments, to live in a value-concordant way, to be empowered, and to experience giving as well as receiving?

To make this more concrete, the empirical evidence suggests that staff working in mental health services hold stigmatising views about mental illness[70]. How might this change? One approach is to increase cultural competence, the ability to work with people without imposing culture-based filters of meaning on the interaction[188]. In relation to recovery, cultural competence can be viewed as a means to an end. The end is working with each person as an individual, rather than defining the person in terms of stereotypes and group norms. The development of skills in cultural competence can be an important step towards that end. The Yale Program for Recovery and Community Health (www.yale.edu/prch) teaches five cultural tenets:

1. Working with clients is inevitably a cross-cultural enterprise
2. Becoming culturally competent is a process not an end point
3. A central part of working effectively across cultures is becoming aware of our personal cultural filters

4. Group-specific information can be used as a starting point for exploring individual experiences

5. Stereotyping is a natural part of the human perception process, but is one we need to be aware of and challenge.

For the patient, integration of the direct meaning of the mental illness into personal and social identity is a key step on the journey of recovery. It is also a very personal process – it cannot be done to the person, so assessment involves working with the person to help them develop their own explanation. The process of integration normally starts with the quest for direct meaning – making sense of what has been, and is, happening. A desire for many patients will be to reduce anxiety by wanting an answer from the expert. Therefore part of the assessment will involve collecting enough information to be able to offer a clinical perspective, and to develop treatment goals (which we cover in Chapter 17). This perspective will be an important resource for some patients, for whom receiving a diagnosis can be immensely helpful:

> It just made sense of not sleeping, waking up early and not being able to get to sleep and not being able to eat, being constantly worried about what was going to happen.[186]
>
> It is impossible for any sane person even to begin to imagine how I felt. It is also obvious to anyone with a shred of common sense that I was ill. Any characterisation of my behaviour as 'bizarre', that such an 'illness' attribution would then be an act of social control (to empower the medical profession), is clearly absurd.[67]
>
> I found it kind of liberating. For a while I could receive the absolution I needed for failing to do the things I usually did. My relationships with friends and family improved: I had not simply become lazy, unreliable and extremely irritable, now there was something 'wrong'.[76]

There should be no withholding of a view about diagnosis, but there should also be a tentativeness in how it is used in the assessment process. It is a resource to offer to the patient, not 'the' answer. The anxiety containment achieved through a diagnosis can be real, in showing that others have experienced similar things. But it can also be illusory if the patient thinks a diagnosis is an explanation (when it is a description), and can actively impede recovery if the patient expects the expert, who now knows what's going on, to cure them. For many, perhaps most, people with mental illness, there is no magic bullet, despite what they may hope for from the clinician. The reality is that recovery involves innumerable small acts. Nothing more. And nothing less. Tentativeness in communicating a clinical perspective therefore needs to be genuine, rather than a therapeutic manoeuvre to soften the blow of diagnostic reality.

Recovery-focussed clinicians know that the meaning of choice is the choice of meaning. If recovery is 'a manifestation of empowerment'[470], then it potentially 'involves the individual rejecting labels linked to psychiatric disabilities and regaining a sense of personal integrity'[333]. Nurturing this process of empowerment involves a willingness to accept that clinical explanations may not be helpful for every individual, and to actively support the person to access other sources of meaning, such as spirituality (discussed in Chapter 10) or self-help groups (Chapter 12). A marker that the focus is on personal rather than clinical meaning is when the idea of a *Coming Off Diagnosis* group to support users of mental health services to develop their own framing of their experiences is understood rather than ridiculed.

In practice, this all adds up to a clinical assessment involving a stance of enquiring about, and expecting to find together, some meaning in the experience, whilst giving

primacy to the views of the patient not the professional. This does not of course imply that what the person currently believes is necessarily true in an objective sense, but that the basic orientation of the assessment process is towards helping the patient and the clinician to understand the experience, rather than to explain the cause. Glenn Roberts identifies three approaches in relation to experiences of psychosis[83]:

1. Finding specific and concrete meanings

This involves listening without filtering through a clinical model, to understand the developmental and autobiographical context in which experiences take place. In psychosis, for example, the guiding question might be 'Has this in some sense actually happened to the person?'. Most commonly the experience that is clinically seen as a delusional belief won't have literally happened, but may have happened in a different context or time, such as the person experiencing persecutory delusion who was abused as a child. Making sense at this level is directly and powerfully therapeutic, in creating a space to develop non-psychotic ways of engaging with the underlying issue.

2. Understanding metaphoric or thematic associations

This involves following the feeling, or emergent themes, in the way the person talks about their experiences – viewing delusions as unlabelled metaphors[471]. The level of meaning might be a pervasive sense of powerlessness, guilt, shame or lack of value, or identification with the role of victim. The advantage of this approach is that it both normalises the experience – you don't have to have a mental illness to have unresolved issues – and provides an opportunity to support the person in developing self-awareness and new identity formation.

3. Understanding the purpose and significance of an individual's elaboration of their psychosis

This final approach involves setting aside entirely the issue of where the experiences have come from, and focussing instead on what maintains and reinforces the person's interpretation. The guiding question might be 'Is this a helpful way for the individual to make sense of their experiences?'. The advantage of this approach is that it leads to a hope-promoting focus on making the future better, rather than a hope-destroying account of the individual as incomprehensible. As Roberts puts it[83]:

> there is a perennial risk that this backward search for meanings can become endless, and a problem in its own right. Any gardener knows that digging up the roots is not a good way to promote growth . . . [T]he purpose of understanding is not to 'crack the code', but always in the service of supporting the individual's journey in recovery and getting on with life.
>
> (p. 94)

Three levels of understanding are thus being differentiated:

*   Understanding the meaning *of* madness – how does it arise?
*   Understanding meaning *in* madness – either specific or metaphorical
*   Understanding meaning *through* madness – existential considerations.

This effort to understand can offer a buttress against the damaging clinical tendency to pathologise. For example, when confronted with someone hearing voices, the traditional instinctive clinical response is:

*   To give primacy to voice-hearing, and hence ignore the social context, other problems the person is experiencing, and their strengths and abilities
*   To link voice-hearing with schizophrenia, when other explanatory frameworks exist[42]

- To assume that medication is necessary, when alternative responses exist[472]
- To define the experience as a mental illness, and consequently to locate the person in a role as a person with a mental illness, despite its stigmatising consequences.

  Many consumers report feeling pathologised by mental health services[473]:

  > Some people will try to tell you that your anger is a symptom of mental illness. Don't believe them. Anger is not a symptom of mental illness. Some people may even try to medicate you in order to make your anger go away. This can be dangerous – by extinguishing someone's anger we run the risk of breaking their spirit and of wounding their dignity . . . Your anger is not a symptom of mental illness. Your angry indignation is a sane response to the situation you are facing.

The outcome of the individual's quest for meaning may or may not be consistent with a clinical perspective. A recovery value is that it doesn't matter! Most people have idiosyncratic views which would seem odd to some external observers. It is not the job of mental health services to make people rational. Nor is it their job to make people normal; mental health services overvalue the bland. As Pat Deegan put it[474]:'The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human'. Self-awareness about values and avoiding the implicit prioritisation of rationality and normality are difficult tasks for clinicians. Pragmatic suggestions to support this process include:

1. Involving people with lived experience as workers in mental health services is an aid for mental health professionals in engaging in a recovery-supporting way with patients, as we discussed in Chapter 12.
2. Developing new scripts which validate personal meaning. For example, responding to 'I have schizophrenia' with 'I'm wondering if that's what you think or what other people have said about you?'.
3. Creating opportunities for the professional to meet voice-hearers:
   a. who accept the voices as being real, e.g. through the Hearing Voices Network (www.hearing-voices.org)
   b. outside the normal clinical context, e.g. through trialogues (Case study 26)
   c. who are further along in their recovery journey, e.g. as colleagues in consumer-employee roles.
4. Applying cognitive-behavioural insights based on social rank theory[475] to understand that the relationship between the voice-hearer and their voice is a social relationship, and so issues of victimhood, power, fear and empowerment are valid assessment topics.
5. Experimenting in asking about strengths as well as deficits, to challenge the confirmation bias involved in a deficit-focussed assessment.

For example, understanding the person's behaviour as an effort to cope with their experiences rather than as a symptom of mental illness can be helpful. The study of approaches to coping has a long history. Much of the work is influenced by the Cognitive Appraisal Model (also known as the Transactional Model) of Richard Lazarus. In this model, coping is defined as[476]:

> constantly changing cognitive and behavioral efforts to manage specific external and/ or internal demands that are appraised as taxing or exceeding the resources of the person.

(p. 141)

Coping strategies are cognitive and behavioural responses intended to reduce either the gap between reality (environmental outcomes) and wants (ideal self-image), or the threat (cognitive dissonance) associated with the gap. The model proposes that people do not unthinkingly react to change, e.g. symptoms. Rather, coping responses are generated by: (i) appraising the situation, e.g. in terms of demands, threats, opportunities; (ii) identifying the available resources for managing the situation; and (iii) estimating the consequences of different responses. Therefore, coping responses are influenced by appraisal (e.g. controllability, relevance) and may have effects on motivation, cognition, emotion or interpersonal functioning.

The model is of course limited – no one is always rational and the person may be stuck in unhelpful response patterns. However, the merit of the model is that each element provides a potential point of clinical action. For the anxious person, developing skills in reducing hyper-vigilance to threat alert will enhance coping ability. For the depressed person, exploring beliefs about support available from others may increase the available resources. For the person with a substance abuse problem, motivational interviewing to identify all effects of the behaviour may increase motivation to change.

There is no shortage of lists of coping strategies, from 161 derived from existing measures[477], to 66 different cognitive and behavioural strategies to deal with negative events[478]. Two relevant superordinate groupings have been proposed. The first grouping differentiates between the focus of the coping response[476]. Problem-focussed coping involves changing the environment, to remove obstacles blocking successful striving. Emotion-focussed coping (also known as reorganisation strategies[479]) involves intrapsychic change to reduce the mismatch or perceived threat. Meaning-focussed coping (also known as reappraisal coping[479]) involves re-framing the meaning of the event or situation to make it more compatible with beliefs and goals. These categories have predictive value. For example, perceiving a diagnosis of HIV/AIDS as a challenge (i.e. amenable to change) is associated with experiencing more control over the illness (meaning-focussed coping), using more problem-focussed coping and social support, and better emotional well-being[480].

The second grouping is into avoidance versus approach strategies[481]. This distinction refers to whether the focus is towards or away from a problem or negative event. Approach strategies deal with a mismatch between self and environment by actively confronting the problem. Avoidance strategies either deny the mismatch or seek to escape the damaging consequences.

Combining these two groupings gives four classes of coping response, shown in Table 16.2.

The final column of Table 16.2 indicates how these coping responses can be interpreted clinically. The fact that these are all negative labels may stand out, although this is inevitable when clinical terminology describes deficits and not strengths. What from the outside can appear to be symptoms of mental illness can be interpreted very differently. Understanding normalises these processes, which otherwise would be pathologised.

We now identify approaches to a balanced assessment of strengths and deficits.

Using assessment to amplify strengths

In Chapter 2 we identified how a clinical model leads to a negative bias in assessment. We noted that clinical assessment should focus on four dimensions[57]:

1. Deficiencies and undermining characteristics of the person
2. Strengths and assets of the person
3. Lacks and destructive factors in the environment
4. Resource and opportunities in the environment.

Table 16.2 Coping styles

	Coping response	Thoughts	Feelings	Behaviours	Clinical interpretation
Emotional avoidance	Emotionally withdraw from a too-painful reality	'There's no problem'	Drained, dead inside, wrung out, heavy, anxious, depressed	Drug and alcohol over-use Social isolation Day-dreaming Excessive sleep Giving up	Disengaged Amotivational Affective blunting Passivity Lacking insight
Re-framing	Try to make sense of the situation in a way that fits with current beliefs	'I can make sense of what's happened without changing myself'	Suspicious, anxious, afraid, alone, uncertain, angry	'Odd' behaviour Increased religious activity	Paranoid Delusional Reasoning bias Lacking insight
Active engagement	Try to change the world to fit with beliefs	'I can change the situation without changing myself'	Engaged, angry	Challenging	Non-compliant Manipulative
Integration	Change beliefs, values and goals to better fit reality	'This is how things are. So now what . . .?'	Acceptance, combined happiness and sadness	Ventilation of feelings Use of social support	

Assessing a person in a way which does not overly focus on negatives is difficult, for several reasons. First, it is hard work. Each dimension is dynamic and changing, and interdependent in complex ways. Holding this complexity is intellectually demanding, and requires a tentative stance and openness to changing understanding. It is much easier and in some ways more rewarding to be the clinical expert, who can summarise the problems of the person (i.e. Dimension 1) with a pithy piece of professional language. This issue will reduce with the development of a shared taxonomy and language for Dimensions 2 to 4. This is beginning to emerge. For example, the concept of character strengths has been disaggregated into six core virtues of wisdom, courage, humanity, justice, temperance and transcendence[482]. Similarly, positive affect has been disaggregated into Joviality (e.g. cheerful, happy, enthusiastic), Self-Assurance (e.g. confident, strong, daring) and Attentiveness (e.g. alert, concentrating, determined)[483].

Second, the expectation in the mental health system that it is the person who is going to be treated inevitably leads to a focus of attention on the individual. This of course is a consequence of clinical (and patient) beliefs about what the job is, and doesn't have to be the case. The importance of the wider context is considered further in Chapter 23.

Third, the clinician's illusion means that professionals don't see people as often when they are coping[323], so they gain the false impression they cannot cope or self-right. So Dimension 1 (and to some extent Dimension 3) tends to dominate clinical interactions. Case study 25 includes strategies to address this issue.

Finally, the questions clinicians ask impose a structure on the dialogue, and influence content. The highly practised deficits-focussed discourse of taking a history systematically

identifies all the deficient, inexplicable, different and abnormal qualities and experiences of the person. This focus on deficits (and the other Ds: difficulties, disappointment, diagnosis, disease, disability, disempowerment, disenfranchisement, demoralisation, dysfunction) reinforces an illness identity, and the person disappears. Up close, nobody is normal: a deficit-focussed discourse will always elicit confirmatory evidence for an illness-saturated view of the person. Since illness is a negatively valued state, this bias adversely shapes how the person is seen by themselves and others.

Deficits, risk and symptoms are important, and so structured approaches to their assessment are an important clinical skill. However, there is no established structured dialogue, equivalent to a mental state examination, to identify a person's strengths, values, coping strategies, dreams, goals and aspirations. What might this look like? This will involve assessment of mental health. In Box 16.1 a Mental Health Assessment is proposed, with the equivalent elements from a standard history-taking interview shown in square brackets. The assessment is consistent with the Complete State Model of Mental Health[418] introduced in Chapter 14, and informed by empirical research reviewed in Chapter 2.

Of course, this discourse would be irrelevant for a clinician who sees their job as diagnosing and treating, and irritating for a patient who wants the clinician to tell them what the problem is and how to address it. So role expectations are central, and recovery-focussed clinicians hold different expectations about the primary purpose of their role.

The Mental Health Assessment is also clearly one-sided, systematically ignoring the negative part of the story and unlikely to yield a balanced picture. This is, of course, the point – problems and deficits should not be the *only* dimension assessed. The more we seek out and elaborate actual and potential mental well-being, the less we see (and support, and create) mental illness. A balanced approach is needed, and Box 16.1 is intended to provide a corrective to the conventional imbalance.

Another approach is embedded in the Appreciative Listening Cycle[484]. This contrasts with the Problem Focus Cycle, shown in Figure 16.1.

The Problem Focus Cycle has two anti-recovery features. First, it focuses on problems, thus reinforcing an illness identity and neglecting the innate, growth-oriented capacities and strengths of the individual. Its orientation is towards objectifying the person, by seeing the problem as primary. Hence there is great attention paid to compliance, with the embedded assumption that non-compliance is undesirable. Yet for people without a mental illness, there is much greater ambivalence about challenging rules – sometimes opposition and independence are highly valued.

Second, by starting with a professional imposition of meaning, the remainder of the process (no matter how sensitively done and patient-focussed) is inevitably clinician-led. For example, clinicians of course differ in the extent to which they involve the patient in decision-making, but the consistent assumption built into this process is that the clinician knows the best solution: the intervention may need to be tailored to the patient, but starts with and is based on clinical expertise rather than the expertise of lived experience.

In a recovery-focussed service, certain assumptions are turned on their head. This is one. In a partnership relationship, the assumption is that the patient knows the best solution – it is after all their life. Of course, their view may benefit from the input of clinical expertise. But this characteristic of a paradigm shift – what was previously of peripheral interest (the patient's view) becomes central – is present in a recovery-focussed system. We discuss this further in Chapter 26.

In the Appreciative Listening Cycle, the starting point is called the consumer's passions. This is shown in Figure 16.2.

Box 16.1 Mental Health Assessment

Current strengths and resources [History of the presenting illness]
How are you making sense of what's going on in your life at present? What keeps you going? How have you found the strength to get this far? What do you have going for you? Consider spirituality, social roles, cultural/political identity, self-belief, life skills, toughness, resilience, humour, environmental mastery, support from others, ability to take a philosophical approach to life or to express emotion artistically.

Learning from the past [Precipitating events]
Was there a time when it became more difficult to cope? Why was that, do you think? What would turn the situation around? What have these experiences taught you? Are there any positive ways in which you have changed or grown as a person? Consider gratitude, altruism, empathy, compassion, self-acceptance, self-efficacy, meaning.

Personal goals [Risk assessment]
How would you like your life to be different? If you woke up tomorrow and the problem had gone away, how would you know? What would you notice had changed about yourself, and what would others notice about you? What are your dreams now? How have they changed?

Past coping history [Past psychiatric history]
How have you got through the tough times in your life? What supports have you found useful? What do you wish had happened?

Inherited resources [Genetic background]
Is there any history of high achieving in your family? Any artists, authors, athletes or academics?

Family environment [Family environment]
When you were growing up, was there anyone you really admired? Who was the most kind person to you? Who taught you the most? Who did you want to be like? What important lessons did you learn during childhood?

Developmental history [Developmental history]
What was life like for you when you were growing up? What did you enjoy? What's your best memory? What skills or abilities did you discover you had? What came easily to you?

Valued social roles [Occupational history]
How would you describe yourself? How do other people see you? What would someone who knew you really well and liked you say? What would you like them to say? How are you useful or of value to others?

Social supports [Relationship history]
Who do you lean on in times of trouble? Who leans on you?

Personal gifts [Forensic history, drug and alcohol]
What is special about you? Has anyone ever paid you a compliment? What do you like about yourself? What things that you've done or ways that you've behaved make you feel really proud of yourself?

Personal recovery [Premorbid personality]
Do you have a sense of who you were before these problems? How did you feel about that person back then? Do you want to go back to how you were, or become someone new? What bits of yourself then would you hold on to?
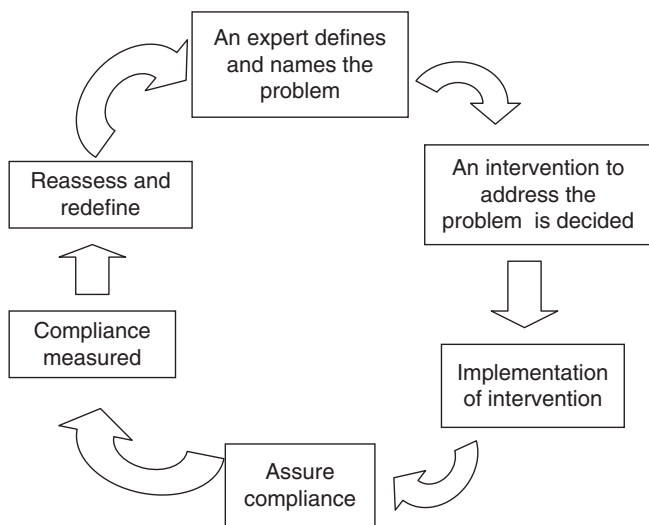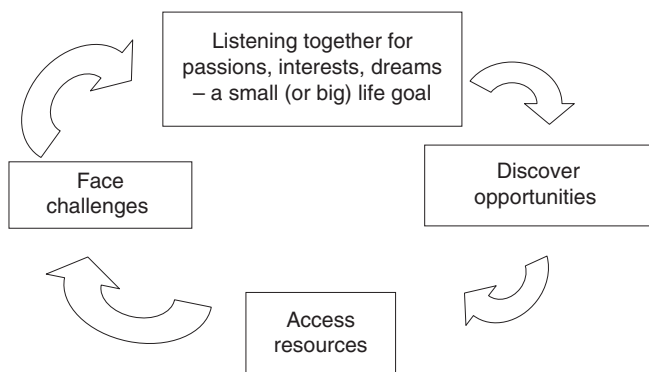
Figure 16.1 The Problem Focus Cycle.

An expert defines and names the problem

An intervention to address the problem is decided

Implementation of intervention

Assure compliance

Compliance measured

Reassess and redefine

Figure 16.2 The Appreciative Listening Cycle.

Listening together for passions, interests, dreams – a small (or big) life goal

Discover opportunities

Access resources

Face challenges

The approach emerges from the appreciative listening enquiry field, in which the four steps are labelled as Discover, Dream, Design and Destiny[485]. It starts by identifying something – anything – that matters to the individual, and then working together towards that goal. The slips along the road to meeting the person's goals become normalised as challenges, rather than compliance issues. Setbacks become the jumping-off point for new growth and learning, rather than treatment failures. Of course, some setbacks may relate to mental illness, but the key difference is that they are not the start point. Pharmacological and psychological treatments for mental illness often will be one means of facing a challenge, but this is in service to the person's goals – a means, not an end.

The Appreciative Listening Cycle does something the Problem Focus Cycle does not: it locates the responsibility for change with the individual. This does not mean the person is unsupported or abandoned. There may be substantial effort going into skill-building and staff-intensive support may be needed to reach the goal and deal with setbacks. But it creates the possibility of generating surprise: 'I did it!'. This type of surprise is the bed-rock of resilience.

Another assessment approach builds on the character strengths concept introduced in Chapter 14. These comprise one's highest strengths, and have been disaggregated into virtues of wisdom, courage, humanity, justice, temperance and transcendence[482]. This framework underpins the Values in Action Inventory of Strengths (VIAS)[482], which is available as a 240-item online questionnaire at www.viastrengths.org. After completion, the respondent is presented with a list of their five top 'signature' strengths. Consistent with its origins, the questionnaire reflects US values, and under-emphasises strengths valued more highly in other cultures such as patience and forbearance[486]. It also focusses on individual-level strengths, thus neglecting familial and cultural strengths such as connectedness. However, a 54-country study involving 117 676 internet respondents demonstrated a high level of consistency in the profile of character strengths internationally[487], and VIAS provides a theoretically based and empirically established counterbalance to assessment of deficits.

The VIAS has been used by a psychiatric rehabilitation centre, with very positive findings[342]:

> The survey creates a mindset of serious and effortful self-appraisal . . . at the conclusion . . . most participants report feelings of pride and expansiveness, with the discovery of a self that is invariably better than expected . . .
> Some . . . report a sense of accomplishment and mastery from merely completing the assessment. Most report that their mood improves after receiving their results and they think more positively about themselves.
>
> (p. 121)

The general principle across all these approaches is a stance of expecting to find more than just problems. The importance of nurturing a non-illness-based identity is central to the accounts of many people experiencing recovery[330]:

> Having joy is one way to stay out of depression.
> It was just realizing . . . that life isn't one big horror.
> At least [now] I've got something to think about other than to think about the bad part, the lonely part. At least I know I can think about: I'm going to go out with [my friend]. It's only lunch, but it'll be good.
>
> (pp. 154–155)

One aim of identifying strengths is to activate the person's capacity to take responsibility for their own life.

Using assessment to foster personal responsibility

An unintended consequence of clinicians working so hard to look after people with mental illness can be a reluctance to allow individuals to take responsibility for their own life. Clinicians need to get out of the way of the person's recovery. This means supporting the individual to take as much personal responsibility as possible, rather than assuming responsibility for them. The clinical job is to support and amplify the individual's efforts towards recovery, by avoiding as far as possible detached relationships, deficit-focussed assessments, doing-to treatments, and drip-feeding responsibility back to the person. This transition in responsibility needs to be managed in a skilful rather than abandoning way, a balance understood by people using mental health services[55]:

> Over the years I've realised that support services can do too much as well as too little.
> I have learned to recognize when to stop my reliance on the support of professionals.

> If I hadn't taken risks to get well in the past, I might still be in a sort of low-level state.
> I might have had only one spell in hospital rather than a dozen, but I doubt
> I would be where I'm at today.
>
> (p. 56)

This can be difficult for clinicians, who are generally highly caring and want the best for the people with whom they work. They will have experience of people being allowed to make their own choices with damaging consequences. Staff may need support to work in a responsibility-promoting way, e.g. by linking this behaviour with the values of self-determination and personal responsibility.

This is one area where rehabilitation services and CBT both have relevant expertise, in their emphasis on the ability of the individual to make a difference to their life, rather than being a passive victim of an illness or recipient of treatment. Clinical communication skills remain central. For example, with some service users it may be more helpful to talk about personal resourcefulness (which points to creativity) than personal responsibility (which some people may feel is imposing expectations on them).

What practical difference does this orientation make? One example is in goal-setting activity. Many people experience difficulty in developing purposive activity. Clinicians can support this by using person-centred questioning: 'When have you most felt alive?', 'When did you last have fun / laugh out loud?', 'What would make a difference in your life?', 'What are your dreams?', 'What do you want in life?', 'What would make your life better?', 'What would give your life more meaning?', 'What would make your life more enjoyable?', etc. The challenge is then *not* to get in the way by assuming responsibility, for example through helping the client to decide whether the goal is realistic, or identifying *for the person* the steps towards their goal. This is not of course to argue that people don't need support – of course they do. Rather, it is arguing that the instinctive response needs to be locating the responsibility for change with the person.

The antidote to the clinical tendency to assume responsibility is to use coaching skills for supporting partnership relationships: 'What would it take to meet this goal?', 'What would happen if you challenge the rule that says you're not allowed to do that?', etc. Mental health clinicians need expertise in facilitating, not in doing. The resulting authentic and mutual relationship with the consumer has greater potential for healing than a relationship focussed on treatment and cure.

Using assessment to support a positive identity

One thing professionals know is that the experience of mental illness will almost certainly change the person. Researchers asking people about recovery found that[488]: 'some of the participants talk about becoming *different* people as a result of their illness, others talk about becoming *better* people' (p. 239). Changes in identity during personal recovery are as individual as any other recovery process[489]. However, two broad types of change can be distinguished: redefining existing elements of identity (identity re-definition) and developing new elements (identity growth). Some examples of identity-transforming beliefs in relation to direct and indirect meaning are shown in Table 16.3.

Identity transformation is presented in Table 16.3 by describing new beliefs, but it is of course a much deeper process, involving a core sense of who the person is. Recovery-focussed clinicians know that this identity work begins as soon as possible: focussing solely on cure of the mental illness gets in the way of supporting people to live good lives now. Health is not promoted simply by reducing illness, just as life cannot be lived just by minimising dysfunction.

Table 16.3 Identity redefinition and identity growth

	Identity change	Examples of transformative beliefs	Why this helps
Direct meaning of mental illness	*Redefinition*	My mental illness means I cannot function *some of the time*, rather than all the time	I can lead my life the rest of the time
		I have more control than anyone else over my mental illness	Increased agency and empowerment
	Growth	My mental illness has led me to understand myself in new ways	(a) increased self-knowledge; (b) value and meaning placed on experience
		Other people have been like me and recovered	(a) normalising of experience; (b) hope-promoting
Indirect meaning for the person	*Redefinition*	My mental illness has happened because of my childhood	(a) life becomes more meaningful; (b) development of coherent personal narrative
		My mental illness means I am in touch with my creativity	Increased value associated with self as a whole person, rather than self-image as being damaged
	Growth	I am more compassionate to others now	(a) becoming a 'better' person is socially valued; (b) being compassionate with others can lead to greater self-compassion
		My mental illness has given me a job, teaching about mental health issues	(a) development of a social role; (b) using own experiences; (c) benefiting others

It can be difficult to see the person when the illness is very prominent. One approach is to draw from non-mental-health approaches to amplifying a positive identity (e.g. www. bluesalmon.org.uk). Another approach is to use a time-line to help put the person as they are now into the broader context of their own life. Even though the person may be currently struggling to exercise personal responsibility, it is helpful for the clinician to know about their best efforts and successes – creating a shared belief that the person can be expected to re-engage in their life in the future. A third approach is to deliberately increase involvement with the person when well, so that the worker can hold a picture of the well person during crisis (see Case study 25). All of this takes time. A mental health system which only has capacity for a short, symptom-focussed assessment of the patient is a structural impediment to the efforts of clinicians to support recovery.

Assessment at the level of indirect meaning is important, in giving the person a chance to process and make sense of what the mental illness means for them as person. For the clinician, this involves giving the patient an invitation to open up the conversation. Whilst the content of the illness experience may be of central importance to the clinician, for the patient the main concern may be the wider social and temporal context – what does it mean for the person in their environment, and for their past, and their future? This is of course highly individual, but fits with the focus on contextualised meaning rather than decontextualised description. Talking about indirect meaning is a different task from discussing prognosis, which is a component of direct meaning understood within a clinical model. Conversation about indirect meaning also helpfully differentiates between the person and that part of them which is experiencing mental illness.

Using assessment to develop hope

Change at the level of identity is a frightening prospect, and reassurance about the possibility of recovery may be vital. How can this hope for the future be realistically supported, when we cannot know what the future holds for an individual patient?

An organising theoretical model of hope and consequent set of strategies is provided by Russinova[425]. In conjunction with findings from elsewhere[4;426], it is possible to identify values, attitudes and behaviours in mental health professionals which promote hope in the people they work with. These are shown in Table 16.4.

Although this list initially looks very difficult to disagree with, it provides challenges for traditional clinical practice. For example, 'Trust in the authenticity of what the person says' is not compatible with assessing in relation to a predefined clinical model. It requires the cognitive flexibility in the clinician to both value the client's interpretation and to bring professional expertise to bear. This is why the concept of insight is so toxic for personal recovery – it indicates a cognitive stance which views one person (the professional) as right and the other (the patient) as wrong unless they agree. This is not just making the obvious point that it should always be remembered that a delusional belief might be right, no matter how far-fetched it sounds. This is making a more challenging and values-based point, that in a recovery-focussed service the professional perspective does not have automatic primacy over the patient perspective. In a partnership relationship, based on the constructivist

Table 16.4 Strategies for promoting hope

	Using interpersonal resources	Activating internal resources	Accessing external resources
Values	Valuing the person as a unique human being	Failure is a positive sign of engagement, and contributes to self-knowledge	Target efforts towards supporting the person to maintain relationships and social roles
	Trust in the authenticity of what the person says	To be human is to have limitations – the challenge is to exceed or accept them	Find or build an audience to the person's uniqueness, strengths and best efforts
Attitudes	Believing in the person's potential and strength	Losses need to be grieved for	Housing, employment and education are key external resources
	Accepting the person for who they are	The person needs to find meaning in their mental illness, and more importantly in their life	Employ recovered consumers in services as role models
	View set-backs and 'relapse' as part of recovery		
Behaviours	Listening non-judgementally	Support the person to set and reach personally valued goals	Facilitate contact with peer role models and self-help groups
	Tolerate the uncertainty about the person's future	Support the person to develop better approaches to coping	Be available in crisis
	Express and demonstrate a genuine concern for the person's well-being	Help the person to recall previous achievements and positive experiences	Support access to a full range of treatments and information
	Use humour appropriately	Support and actively encourage exploration of spirituality	Support close relationships

epistemology described in Chapter 4, there is no single correct interpretation of reality. Rather, what matters is working together to find an explanation which is helpful to the patient. Recovery begins with hope, and is sustained by acceptance. Hope, not acceptance, is the starting point[474]: 'How can we accept the illness when we have no hope. Why should one pile despair on top of hopelessness? The combination could be fatal. So perhaps people are wise in not accepting the illness until they have the resources to deal with it.'

In practice, this means the assessment conversation between clinician and consumer in a recovery-focussed service may look different, in two ways. First, the topic of interest is the person not the illness, and promotion of well-being is as important as treatment of illness. Therefore the content is not solely about deficits. Second, the discourse is not a one-way relationship, focussed on the clinician assessing the patient and then providing expert advice. Rather, the discourse is as much about helping the consumer to learn about themselves as giving the clinician the information they need. This requires coaching skills, and modesty and tentativeness from the clinician about the limits of their expert knowledge. It will even involve the clinician learning from the consumer.

We close this discussion of promoting hope with two concrete suggestions. First, perhaps the biggest weapon of depression is that it is a killer of hope. Addressing experiences of depression can be an important step towards the person being able to take personal responsibility. Second, it is helpful for clinicians to talk about recovery. The very existence of the concept in clinical discourse has transformative potential, and acts as a counterbalance to the alternative implicit message that long-term contact with mental health services is the norm.

Messages to communicate through assessment

To summarise, mental health services can support recovery during assessment by communicating several messages, shown in Box 16.2.

These messages may differ from what is communicated to people using traditional mental health services. They may to the seasoned clinician even sound naïve, especially in relation to people in crisis. The intention is not to be unrealistic. Chadwick draws on his own experience of psychosis to suggest that[67]: 'when dealing with a newly admitted deluded

---

Box 16.2 Professional-to-patient assessment messages which support recovery

1. The experience you are going through is meaningful, and part of your journey in life. I will use all my expertise to support you to make sense of what is happening to you, working with you to help you to find your own way forward. I don't know what will happen to you, but I do know that many people with similar experiences have recovered their life.
2. Some people with similar experiences find it helpful to make sense of what is going on as a mental illness. Others develop their own meaning through contact with others who have been through similar experiences. Some make sense of what has happened to them in spiritual terms, or in other ways entirely outside the mental health system.
3. Whatever sense you make of it, you will over time increasingly fit this experience into the bigger picture of who you are as a person. Although you may change as a result, you will control the direction of this change. A point may come where you can even identify good things that have come out of the experience
4. It's fine to hope for miracles, but don't expect them! As you become ready, the challenge will be for you to make decisions about your own life. This is going to be hard work – but you won't be alone.

patient the terms on which you think the interaction is taking place are not anything like the terms as seen from the patient's perspective . . . the patient is literally living and behaving in a different world from you.'

The clinical skill during crisis is to provide a map back to experiencing hope and personal responsibility. If a map is to be of use for navigation, it needs to include the current location, orientation and terrain markers. The skilled recovery-focussed clinician:

- Connects with the person where they are, accepting that their unusual beliefs, statements and behaviour are meaningful. Accepting involves not imposing an explanatory model, but offering alternative explanations in a tentative and non-authoritative way. This is difficult if you believe that you know for certain what is going on, and professional training which treats as revealed truth one model of understanding will actively impede this skill.

- Will offer pointers for the direction of travel. This can involve discussion about help and support which is available now or when the person is ready, overt discussions about power ('for the moment I have had to take control over your life, and this is what needs to happen for me to give this power back'), positive goal-setting, being a holder of hope for the person when they are hopeless, or being a spring safety-net instead of a sagging safety-net by actively easing the person back into their life.

- Will use their expertise-by-training as a resource for the client. This might involve 'Other people I have worked with have found X useful', or 'Although it's hard right now to even think about talking about what you are going through, as soon as you do manage to disclose even a small part you may well experience a real sense of achievement. It will probably still hurt, but it will be the pain of healing'.

Sometimes the view is put forward that professional expertise is devalued in a recovery-focussed service. In fact, it is realistically valued. It is not treated as revealed truth – but then nor should it be. It is an important resource for service users to draw on.

The purpose of assessment is to develop goal-oriented action plans, to which we now turn.

Action planning

In a mental health service focussed on personal recovery, assessment leads to the identification of two types of goal: those arising from the person; and those arising from societally imposed behavioural constraints or perceptions by others (e.g. clinicians) about best interests. It is helpful to distinguish between goals that are important *to* the person and goals that are important *for* the person[490].

Recovery goals are the individual's dreams and aspirations. They are influenced by personality and values. They are unique, often idiosyncratic. They are forward-looking, although they may of course involve the past. They harness approach motivation (focussing on what the person actively wants) rather than avoidance motivation (focussing on what the person wants to avoid). Recovery goals are strengths-based and oriented towards reinforcing a positive identity and developing valued social roles. They can be challenging to mental health professionals, either because they seem unrealistic or inappropriate, or supporting them is outside the professional role. They sometimes involve effort by the professional, or they may have nothing to do with mental health services. They always require the consumer to take personal responsibility and put in effort. Recovery goals are set by the consumer, and are dreams with deadlines[491].

Treatment goals arise from the societal requirements and professional obligations imposed on mental health services to constrain and control behaviour and improve health. The person with a history of severe self-neglect may need regular clinical assessment. The person who becomes rapidly unable to cope with the responsibilities of child-care may need assessment by social services. The person who is actively suicidal may need to be assessed for compulsory hospitalisation. The person who becomes dangerous due to command hallucinations may need compliance with antipsychotic medication to be monitored. Treatment goals are set by the clinician, on the basis of societal, legal and professional requirements. These goals will normally relate to serious harmful risk, symptoms, medication and lifestyle choices. They will be about minimising the impact of an illness and avoiding bad things happening, such as relapse, hospitalisation, harmful risk, etc. The resulting actions will often be doing-to tasks undertaken by the clinician. Treatment goals and associated actions provide the basis of defensible practice, and are important and necessary. They may be signed off by the consumer to show they have seen them, and the consumer will be as involved in the process as possible, and may negotiate specific elements, but they are not the consumer's goals.

Recovery goals and treatment goals are different. A simple exercise to highlight this difference is to ask a group of clinicians to each highlight three things which keep them well, and help them to cope with stresses in life. Then compare this list with care plan items. It is likely that the clinician-generated list will focus on well-being and natural life supports (e.g. family, friends, spirituality, work, love, nature, personal interests), whereas the care plan list will focus on treatment of illness. This highlights the assumption that people with

mental illness need treatment, whereas everyone else needs well-being – a perspective of fundamental otherness which needs to change before a recovery focus is possible. Recovery goals look like the goals of people with no mental illness. They are based on approach-motivation, and support flourishing and thriving – rather than compliance-oriented treatment goals which use avoidance-motivation with the aim of surviving and getting by.

This dichotomy is potentially unhelpful, in two ways. First, it suggests that clinical and consumer priorities are intrinsically opposed. This is not the case. Sometimes a recovery goal and a treatment goal are the same – reducing distress might be the individual's and the clinician's goal. Sometimes the person will agree with a treatment goal as a means towards a personally valued end – taking medication in order to be able to concentrate at work. But sometimes there is no overlap between these two types of goal. Second, it creates the impression that working in a recovery-focussed way can be done by getting someone else to develop recovery goals with the consumer whilst the clinician continues with traditional treatment planning. This is not the intention – supporting recovery is the job of clinicians!

Distinguishing between recovery goals and treatment goals has several advantages:

1. **It is honest**
   It does not maintain a pretence that everything in a care plan is necessarily in the person's interest.

2. **It promotes a focus on values**
   More clearly identifying actions professionals have to do makes power, choice and control issues more explicit and hence amenable to debate – both at the individual clinician level (through an increased emphasis on reflective practice) and at the sociopolitical level.

3. **It promotes a focus on the patient's aspirations and preferences**
   Trying to make the recovery goals of the patient explicit highlights the need to support the person to identify their goals and preferred methods of goal attainment. This places their views at the heart of action planning.

4. **It reduces compulsion**
   For the clinician, a stronger orientation towards promoting self-determination leads to a corresponding orientation away from overruling the individual in their choices. For the service user, the more that clinical effort is directed towards recovery goals, the less the person offers resistance.

5. **It promotes partnership**
   Identifying treatment goals as 'the beast to feed' (i.e. externalising this imperative as something to which both parties are subject and which requires certain actions, irrespective of personal opinions) positions doing-to tasks as a joint problem – allowing clinicians and patients to work towards a joint goal of reducing monitoring and compulsion. A professional orientation towards supporting recovery goals means that it is not for them to decide what is realistic, although they may raise this concern where applicable and work with the service user to break down the recovery goal into smaller steps.

The process of developing treatment goals needs no elaboration, since it is at the heart of traditional clinical practice. But how can recovery goals be explored? A range of simple questions can be used:

- Ask the person what they want from life, and validate their response
- Ask the person about their dreams when they were younger – what did they used to want before the mental illness? Do they still want it, or have they changed towards other goals?

- Ask what life would be like without the mental illness: 'If you could wave a magic wand and wake up tomorrow without this illness, how would you know it has gone? What would be different? What could you do tomorrow that you can't do today?'

We now describe some more systematic approaches (among others[491;492]) to support the identification of recovery goals.

Working to recovery is a work-book developed by Ron Coleman and colleagues, which provides a personal planning tool for recovery[493]. Initial topics are: What recovery means to me; About myself; My needs; and My strengths. It covers stepping-stones to recovery, including relationships with others (such as 'map makers' to recovery) and with the four selves (confidence, esteem, awareness and acceptance). It helps identify positive and negative feelings about the mental illness, and looks at choices and experiences during the mental health career, including experiences with the care planning process, medication, other mainstream treatments and complementary therapy. It finishes with a personal development plan, identifying priorities, goals and anticipated support needs.

Pathways to recovery is a work-book which supports the journey of exploration, self-discovery and planning[494]. It focusses on the domains of life which people need to thrive, such as a sense of home, increasing knowledge and education, finding work or volunteer activities that bring satisfaction, developing meaningful relationships with others, achieving intimacy and enhancing sexuality, attaining higher levels of wellness, and exploring spirituality. An important feature is the inclusion of over 30 first-person accounts of recovery. It is intended to support the development of a positive non-illness identity.

The focus in **Wellness Recovery Action Planning (WRAP)** is on self-managing mental illness[351]. WRAP was developed by Mary-Ellen Copeland, and now widely used in many countries (see www.mentalhealthrecovery.com for more information). It involves a personal process of action planning, covering the following elements:

- What keeps me well
- Patterns of wellness over time
- Personal triggers/buttons
- Early warning signs and action plan
- Ways of coping and self-management
- Support systems
- Crisis planning/advance directives
- Ways of building wellness.

A key feature is that the starting point is wellness. This positions illness experiences as the exception, which can be addressed both through amplifying wellness and through activating extra support if needed. This is consistent with the emphasis on identity in the Personal Recovery Framework.

Most commonly, WRAP is facilitated by people with their own experience of mental illness, either in individual work with clients or in a group-based (e.g. eight-session) training format. Structures supporting the completion of WRAP vary, from being offered by an entirely separate service (e.g. Case study 17) to being a culture change approach (e.g. Case study 25). It can also serve as a required gateway to other programmes (e.g. Case study 24). Some services provide a continuous rolling WRAP training programme, which consumers can start at any point. Requiring all service staff to undertake this training, in which they process something from which they are recovering, can promote experiential learning and reduce stigmatising distinctions.

Some established recovery-focussed services have separate routes for developing recovery goals and developing treatment goals, e.g. Case study 13. By way of contrast, our next case study illustrates an approach to integrating recovery and treatment goals into a single planning process.

Case study 11: person-centred planning

The Yale Program for Recovery and Community Health trains clinicians in person-centred planning[a]. Two key principles inform the process:

1. Personally valued goals are the starting point. They are not the thing to focus on *after* clinical goals such as medication compliance, abstinence and symptom reduction are achieved. For example, referral to supported employment is not delayed until clinical stability is obtained. The planning process is therefore strengths-based, because a deficit-based assessment leads to a crossing off (temporarily or permanently) of many valued social roles (mother, worker, spiritual person).

2. Meeting goals through personal effort and natural supports is preferable to meeting goals through mental health service effort. This reinforces a positive identity, maximises personal responsibility and keeps the person in their life. Focussing on service interventions reinforces the mental patient identity and allows the community to continue discriminating.

Person-centred planning starts by the person identifying goals which promote their recovery, self-determination and community integration. This involves helping the person to connect with their own dreams – either now or when younger. The focus is on identifying goals which promote well-being and thriving, rather than avoiding illness problems and getting by. Identified goals are often big, and always meaningful. Goals are never about receiving treatment as a goal in itself, but will often involve treatment as a component of progressing towards personally valued goals.

Objectives or stepping-stone actions are then set for each goal. Every objective is linked to specific goals – everything for a purpose. Objectives have deadlines, to create a sense of momentum and an expectation of progress. They should be achievable and, as far as possible, enjoyable. They are positive: 'The person will . . .' rather than 'The person will not'. Person-first language ('person with depression' rather than 'depressive') emphasises the personhood rather than the illness identity.

Objectives harness strengths. For example, a person who takes their medication irregularly may be viewed as 'non-compliant', with a resulting action of 'Monitor to ensure medication is taken as prescribed'. Viewed from a strengths-based perspective, this person might be seen as 'making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medication', leading to an action 'Work collaboratively to develop a contingency plan for when medications are to be used on an "as-needed" basis'. Agency is amplified, because there is a huge difference between someone who uses medication as a recovery tool and someone who requires medication for clinical stability.

In developing objectives, the orientation is towards actions the person can do for themselves, or can achieve by harnessing existing or new natural supports in their life. If the person's goal is intellectual stimulation, then the objective might be going to a book-reading in a bookshop, rather than attending a service-based current affairs group. If the goal is spiritual development, then going to (say) a church may be more supportive of a positive identity than attending a spirituality group specifically for consumers labelled with mental illness. Only when personal resources and natural supports are insufficient is consideration given to a service response – because it is better to get the support from the system than not at all.

> **Case study 11:** (*cont.*)
>
> Structural approaches can help to support person-centred planning. For example, having three parts to the intervention section of each plan: actions to be done by the consumer, ways in which the person's natural supports will contribute, and actions the mental health service will take.
>
> **Further information:** Janis Tondora (Janis.Tondora@yale.edu)
>
> *Note*:
> [a]Tondora J, Pocklington S, Osher D, Davidson L. *Implementation of person-centered care and planning: From policy to practice to evaluation*. Washington DC: Substance Abuse and Mental Health Services Administration; 2005.

As a final word on assessment, there is as noted earlier no fundamental incompatibility between recovery goals and treatment goals. The consumer may align precisely with the clinical perspective, or the professional may set treatment goals on the basis of the individual's aspirations. However, this agreement should not be assumed, and consumer involvement in the care planning process has often been nominal, e.g. shown by them signing the plan. The consumer's perspective needs to take primacy if the direction of travel for subsequent action is to be as focussed as possible on promoting personal recovery. In a clinical context, where power is unequally distributed, it is especially important to ensure the consumer's voice is heard. This is why the identification of recovery goals needs to be an explicit focus within the assessment process.

One joint aim can be focussing clinical effort on the goals of the individual. It is self-evident that this will produce greater engagement than targeting clinical imperatives. And yet it will require a shift in values[330]: 'Neither the person's efforts nor our own as professionals should be limited to reducing symptoms and dysfunction. Just as life cannot be lived by minimizing dysfunction alone . . . recovery is not achieved solely through minimizing illness' (p. 160).

A second joint aim can be to reduce the number of treatment goals to zero. This is not to imply that treatment goals are bad – it is not a bad thing to stop someone from, say, harming themselves or others. The point is that where the person is taking responsibility for their own behaviour as part of their recovery goals, there is no need for the professional to manage risk as a treatment goal. Where the person is managing their own symptoms using a variety of approaches, the professional no longer needs to focus on medication compliance. The paradox at the heart of this book is that when the person finds effective ways to get on with their life, there is less need for treatment. Providing effective treatments is therefore not the best starting point. Life is about recovery goals, not treatment goals.

Where the professional and the consumer are solely working towards recovery goals, there is closest alignment and greatest possibility of a partnership relationship. This scenario makes clinical work more effective for the consumer – everyone is pulling in the same direction. Perhaps paradoxically to those who may view the profession of psychiatry as the problem, it also makes the clinical interaction more similar to what takes place in other medical areas. Since most mental health clinicians don't enjoy compulsion, this partnership relationship is also more enjoyable for the professional. A recovery approach is in this sense liberating for both consumers and clinicians.

Once the recovery goals and the treatment goals are identified, action follows.

Supporting the development of self-management skills

Mental health professionals support recovery by offering treatments and interventions which amplify the person's self-management skills. This chapter includes ideas and suggestions as a resource to inform the development of reflective practice. Many of the ideas discussed will not be new to experienced clinicians. The aim is to highlight how offering treatment with an aim of promoting self-management (rather than compliance) can provide a vital resource for supporting recovery.

The offering of treatment

In a recovery-focussed service, access to competently provided effective treatments is a vital support for many people's recovery[120]. However, providing treatment is not the primary purpose of mental health services. A recovery-focussed service supports people to use medication, other treatments and services as a resource in their own recovery[474].

This means that evidence-based treatments are (with two exceptions) offered not imposed. Most professionals have highly developed skills in working with individuals who may be ambivalent or antithetical towards engagement. The challenge is to utilise these professional skills to support the person to engage in *their own life*, rather than in addressing clinical preoccupations. The challenge is to work with (not on) the person: services on tap, not on top.

The secondary functions of treatment are to meet treatment goals and to deal with crises. These are the two exceptions to the principle of offering rather than imposing treatments. Meeting these functions may involve compulsion – things being done to the consumer in a non-negotiated way. Treatment goals will typically relate to issues of risk (discussed in Chapter 20) and safety (Chapter 21).

Mental health services should as much as possible be focussed on recovery goals. The aim of treatment is to foster the development of self-management skills, not to fix the problem. This orientation is based on an assumption that the person has, or will have, capacity to take responsibility for their life. Clinical work starts with supporting the person to work towards their goals, through the development of self-management skills.

Supporting self-management

The primary clinical job is to support the development of self-management skills. A definition of self-management is that it involves[56]:

> The systematic provision of education and supportive interventions by health
> care staff to increase patients' skills and confidence in managing their health problems,
> including regular assessment of progress and problems, goal setting, and problem-
> solving support

(p. 27)

A consumer definition would also emphasise the importance of empowerment, hope, exposure to role models, and working towards personally valued recovery goals. Taking personal responsibility for transforming from an identity as a person with a mental illness to a person in recovery is repeatedly identified in consumer narratives as a necessary step in the recovery journey[120;123;495]. For example[116]:'Recovery is not a gift from doctors but the responsibility of us all . . . We must become confident in our own abilities to change our lives; we must give up being reliant on others doing everything for us.' Taking personal responsibility reduces the experience of victimhood, and increases the person's experience of empowerment[320;332]. It also creates the possibility of success, surprise and transformation – '*First you leap, then you grow wings*' is the motto of the Yale Program for Recovery and Community Health (www.yale.edu/prch).

Two implications arise from this perspective. First, it provides an insight into why some people might be reluctant to give up the role of patient – taking responsibility for one's own life can be scary. Second, it shows that (just like recovery itself) responsibility is something that is taken by the person, not given to the person. Mental health services can only work in ways which support an individual to take personal responsibility for their life – they cannot give responsibility to someone who is unwilling to take it. Yet self-management is a goal worth striving for. There is robust evidence of the benefits of self-management approaches in mental illness[496], including depression[497], anxiety[498] and psychosis[499].

Supporting self-management is a central clinical contribution to recovery. Services need to be engineered towards this goal. For example, role expectations are set from initial contact with a service. If the first contact involves an expert assessing someone in the context of a detached relationship, this sets a trajectory of passivity and responsibility for change being taken by the clinician. Similarly, if the environment is unpleasant or the welcome is unfriendly, this creates a negative impression which is difficult to change. This message is well understood by the customer service industry, which emphasises the central importance of the customer having a positive experience during so-called moments of truth – those few interactions where customers have a high level of emotional energy invested in the outcome. Many recovery-focussed services pay particular attention to how people are welcomed. Simple expedients such as a pleasant rather than oppressive welcoming environment are important. The Yale PRCH is based in a space which contains art exhibits, creating a very different environment for both visitors and workers. Displaying stories of recovery rather than medication information in the waiting room creates different expectations. Providing fresh fruit and drinks costs little, and communicates a message of respect. The first personal contact is also important. Club-houses hire greeters to welcome new members[500]. The Living Room service uses a peer-led triage service, so the first contact of someone in crisis is with a peer rather than a professional worker (see Case study 14).

To understand how self-management can be supported, we need to disaggregate the concept of self-management into agency beliefs, empowerment (behaviours arising from agency), goal-setting and motivation to change.

Supporting the development of agency

A necessary requirement for self-management is a sense of agency: a self-belief that the person can impact on their own life. It can be a difficult process precisely because mental illness often takes away agency, as described by the person with schizophrenia who said all she could do to improve her situation was 'just take my medicine and pray'[501]. Asking someone to take responsibility for their lives before they have that capacity will not benefit

the person. This is not making the case for low expectations – people do often rise to the challenge. It is making the case for support which fits the person's stage of recovery.

Developing a sense of agency can be a painful process for the consumer, often starting with accepting that they have an illness or in other ways finding a direct meaning that fits. This acceptance can involve changes to how the person thinks about and understands challenges in life[118]. Because it can be a painful process, consumers may take time to come to the point of doing that work. The resulting avoidance often expresses itself as a wish to be rescued, fixed, made better – for someone else to take responsibility. Consumers at this point in their recovery cannot identify goals, never overtly disagree with their clinician, and are emotionally, and sometimes physically, disengaged.

Unfortunately this behaviour pattern can create a toxic cocktail with clinical responses. When viewed through a clinical lens, it is easy to pathologise the avoidant behaviour as a personality trait or illness symptom. Responses which potentially decrease agency include focussing on compliance; imposing rather than offering treatments; responding to disagreement with compulsion rather than validation; communicating that the clinician knows the solution to the person's difficulties; and trying to fix the person. These responses get in the way of recovery.

One way of avoiding these responses is through self-awareness by the clinician. Professional training does not sufficiently emphasise the fostering of self-management skills, but clinicians normally have substantial expertise to draw on – from their own life. Awareness of personal experiences of a path being walked in life suddenly coming to an end can foster consciousness about how difficult the ensuing processes can be.

Although the development of a sense of agency by the consumer can be a painful process, it also leads to the paradox of recovery: 'in accepting what we cannot do, we begin to discover who we can be and what we can do'[119]. Over time, these limitations become 'the ground from which spring our own unique possibilities'[502]. If the person currently has a minimal or absent sense of agency, then the development of agency is the goal.

Clinicians can do many things to increase agency: foster hope; identify strengths and dreams; support goal-striving; set the person up to experience achievement; encourage them to give back to others; create opportunities to access mutual self-help groups; employ peer support workers; give voice to role models of success; support access to experiences of pleasure; amplify personal success; and aid the integration of positive experiences into personal identity.

Even if the consumer has some sense of being able to impact on their life, they need to be able to act on this. So we turn to empowerment.

Supporting the development of empowerment

Empowerment behaviours emerge from agency beliefs. Although much of the literature on empowerment stems from a Western (especially USA) individualistic perspective, we will use empowerment here in its broader sense of behaviours which impact on one's life, whether or not this is at the level of personal identity or other levels, such as spiritual empowerment or social identity.

There are some structural approaches to increasing empowerment. Within services, this can include getting the complaints procedure in place and working, having the option to change clinician, having advance directives in place and routinely used, offering easily accessible WRAP training, and supporting access to self-management resources (e.g. www. glasgowsteps.com). Since the consumer movement is self-advocacy in action, exposure to

peers and other consumers who can model empowerment and demonstrate experience in self-managing can be profound experiences.

Graham Thornicroft identifies strategies to promote empowerment[56]:

1. Ensuring full participation in formulating care plans and crisis plans[503]
2. Providing access to cognitive behavioural therapy to address negative self-stigma[504]
3. Creating user-led and user-run services[500]
4. Developing peer support worker roles in mental health services[505]
5. Advocating for employers to give positive credit for experience of mental illness[506]
6. Supporting user-led evaluation of treatments and services[507].

At the individual clinician–consumer level, empowerment requires skills in self-advocacy: the ability to stick up for yourself. Therefore assertiveness is necessary. Clinicians can support assertiveness by teaching the DESC script – Describe the problem, Explain how it makes you feel, provide a Solution and state the Consequence of the solution[508]. But supporting empowerment involves more than skills training. For example, where a previously passive patient begins to assert their views and priorities, this changes the relationship dynamic: 'When I see a different psychiatrist every time, it makes me feel irritated that I have to tell my story from the start again. I would prefer to see the same person, so that I can build up a trusting relationship with them over time'. The response to this assertion attempt will enhance or hinder the person's efforts towards empowerment. There may be lessons to learn from other areas of life. For example, in education disagreement is valued as integral to learning, and validating approaches have been developed for managing student–teacher differences (see Case study 17). Also, an individual's efforts to self-manage may lead them to try non-mental-health types of help, such as spiritual support or a cultural ceremony. Clinicians need to support rather than pathologise this development.

How can staff practise fostering rather than impeding empowerment? A team-level approach is to allocate a recovery hat to an individual in each clinical team meeting. That person's role is then to be an advocate for patients being discussed, with input focussed on how services are supporting the individual's recovery. It is helpful to rotate the role because: (a) otherwise the person who volunteers is likely to be the in-team recovery champion and their views can be easily marginalised; (b) this ensures everyone practises a recovery perspective, and so it has a cross-team impact; (c) it holds clinicians back from being too negative about the recovery perspective if they will be the person putting it at the next meeting; and (d) it becomes owned by the whole team. This gives clinicians a chance to practise responding to assertion in a validating rather than disempowering way, and links with the discussion in Chapter 16 about understanding the behaviours of patients as attempts to cope with their problems, rather than through a lens of pathology. This approach of reframing behaviours as coping attempts carries over into interventions to support empowerment. COPE is a widely used scale to assess coping behaviours[509], and its sub-scales are shown in Table 18.1.

What can we learn from research using COPE and other measures of coping in relation to recovery? Three clinically relevant findings emerge from research in the UK[510] and USA[511]. First, individuals in recovery often undertake community-based activities, especially in impersonal public settings such as shopping centres and fast-food restaurants which are characterised by brief (and perhaps superficial) social interactions. This points to a clinical focus on supporting the person to remain connected into their community, discussed further in Chapter 23. Second, a focus on spirituality is common. This can range from occasional meditation or prayer, through attending uplifting religious or secular

Table 18.1 Coping mechanisms and associated behaviours

COPE sub-scale	Behaviour
1. Active coping	Taking action or exerting efforts to remove or circumvent the stressor
2. Planning	Thinking about how to confront the stressor, planning one's active coping efforts
3. Seeking instrumental social support	Seeking assistance, information or advice about what to do
4. Seeking emotional social support	Getting sympathy or emotional support from someone
5. Suppression of competing activities	Suppressing attention to other activities to concentrate on dealing with the stressor
6. Religion	Increased engagement in religious activities
7. Positive reinterpretation and growth	Making the best of the situation by growing from it or viewing it more favourably
8. Restraint coping	Coping passively by holding back one's coping attempts until they can be of use
9. Resignation or acceptance	Accepting the fact that the stressful event has occurred and is real
10. Focus on and venting of emotions	Awareness of one's emotional distress, a tendency to ventilate those feelings
11. Denial	An attempt to reject the reality of the stressful event
12. Mental disengagement	Disengagement from the interfered-with goal, e.g. daydreaming, sleep, self-distraction
13. Behavioural disengagement	Giving up, or withdrawing effort from, efforts to attain the interfered-with goal
14. Alcohol/drug use	Using alcohol and other drugs as a way of disengaging from the stressor
15. Humour	Making jokes about the stressor

activities or an active sense of connection with a Higher Being, to the impressive level of adaptation of one man who founded and led a congregation following the tenets of a religion he created[409]. A spiritual perspective specifically fosters separation of the mental illness from the person, and strategies to support this approach were identified in Chapter 10. Third, linguistic strategies are common. One informant who characterised himself as withdrawn stated that 'I would rather stay home ... one has to find satisfaction in oneself ... before, I was always after people to get something'[128]. The term 'withdrawn' is thus re-framed as intentional and beneficial. This indicates the need to pay close attention to language.

In a recovery-focussed service, there is an orientation towards viewing resistance to change as reasonable, understandable and normal. This leads to a helpful response to people who seem to refuse to take responsibility for themselves, and carry on with apparently damaging behaviours. The traditional clinical approach has been to view the person as the problem. The fundamental shift in a recovery perspective is to see the person as part of the solution. A recovery-focussed approach assumes the person has capacity to take responsibility for their life. The question then moves away from how the clinician can stop the damaging behaviour, and becomes how to support the person to get to a point where they want to stop. The WIIFM Principle motivates the behaviour of most people – What's In It For Me? The challenge is to identify what personally valued recovery goal is being undermined by the behaviour. If this proves impossible, then the behaviour (such as disengaging from

services which are not targeting the individual's goals) may be entirely rational and nothing to do with illness.

So there are many challenges to working in an empowering way, but again this is a goal worth striving for. Services which promote empowerment by working respectfully and with high consumer involvement in decision-making produce better recovery outcomes[395].

The next two steps that arise for an agency-experiencing and empowered consumer are then the identifying of personally valued recovery goals, and initiating movement towards these goals. We discussed how to identify recovery goals in Chapter 17. The only further point to note here is that the development of agency and empowerment do not always precede goal-setting – sometimes the person tries something they don't believe they can attain, and when successful experiences increased mastery and competence.

We turn now to how professionals can support work towards recovery goals.

Supporting the development of motivation

The approach of motivational interviewing addresses how to initiate movement towards recovery goals[512]. Motivational interviewing is a person-centred approach to supporting changes in behaviour through the exploration and resolution of ambivalence, and is oriented towards collaboration, evocation and autonomy. It is based on the trans-theoretical model of change, which distinguishes between precontemplative, contemplative, action and maintenance phases of change[513]. This a relevant distinction in mental health services, because of how common it is for precontemplative and contemplative people to be assumed to be in the action phase. The patient who does not take medication is prescribed an injectable depot to enhance compliance. The patient with abnormal sleep patterns is told to attend a morning activity. The patient who shows problem drinking is put through a detox programme. Treating (literally) a person who is not ready to change as if they are has two toxic consequences. First, it means the action is clinician-centred rather than person-centred, and may not be the type of action the person themselves will ultimately find beneficial. Second, it means that the mental health service and the person are pulling in opposite directions, with the service focussing on compliance, and the patient disengaging, becoming resentful or angry or giving up and exhibiting passivity and dependence. Motivational interviewing offers a more person-centred approach, using techniques for eliciting and amplifying motivation to change such as:

- Ensure person-centredness by using reflective listening to test the hypothesis about what is heard against what is meant: 'It sounds like you . . .', 'You're feeling . . .', 'So you . . .'
- Focus on *why* the person might want to change, not *how* they will change.
- Focus on pro-change motivations: 'Think of your recovery goal. Rate readiness to change behaviour towards the goal on a scale from 1 (not ready) to 10 (fully ready). Why wasn't your rating lower?'
- Undershooting (e.g. 'So your cutting doesn't cause any problems at all for you?')
- Overshooting (e.g. 'So it seems like there's no chance whatsoever you'll be able to meet your goal?')
- Questioning to increase motivation – 'What makes you think you can do it?', 'If you succeed, how will things be different?', 'What were you like before the problem emerged?', 'What worries you about this situation?', 'What's the worst that could happen if you don't make a change?'
- Explore values – 'What are the most important things in your life?'. Note behaviour–value contradictions.

In terms of the clinician–consumer relationships outlined in Chapter 13, motivational interviewing where trust is present promotes a partnership relationship rather than a detached relationship. Recovery is supported where the consumer experiences the resulting treatment as person-centred, enhancing of natural supports, strengths-based and community-focussed[404].

Motivation is created through agency and empowerment and goal-striving, but it is sustained through success. This points to the need to create new rituals in the mental health system. A focus on degradation ceremonies in which a diagnosis is awarded (often many times, as the diagnosis changes) and reinforced through deficit-focussed discourse at out-patient appointments does not support personal recovery. There is a need to create celebration rituals. The next case study shows how one service seeks to make success highly visible.

Case study 12: the Golden Ducky award

At the MHA Village, a high value is put on noticing and celebrating success. This is at its most public in its annual high-profile Golden Ducky awards ceremony. The ceremony involves as much fanfare as possible – organisations are approached to sponsor limousines, red carpets and other accoutrements of awards ceremonies. Attenders dress to impress, with clothing and manicures provided where needed by the Village.

Over 750 members, graduates, staff and other guests receive 100 Golden Ducky awards. The award is based on a video shown to all members, featuring the Sesame Street character Ernie who wants to learn to play the saxophone, but has to learn that he first has to put down his rubber ducky. The need to let go of the mental illness identity is at the heart of the evening, which involves public celebration of achievements by people in the Village 'family' and community heroes from outside who have worked towards this goal.

Awards include:
- Financial Independence – for development of skills in budgeting and money management
- Educational – for completing a formal educational course
- Employment – for maintaining a community employment role for more than 10 months
- Family Booster – for re-connecting with a family, or making a financial, emotional or practical difference
- Living Free – for abstinence from substances
- Independent Living – for maintaining a community apartment for more than a year
- Community Involvement – for making a positive impact on the community.

In 2008 there were 40 graduates, who received Highest Achievement graduation awards at the high-profile ceremony, which includes acceptance speeches, choirs and a reception.

Further information: www.village-isa.org

We have argued that the basic orientation in a recovery-focussed service is towards the promotion of self-management. What does this mean for the traditional clinical imperatives of medication, risk management and compulsory treatment or hospitalisation during relapse? In the next three chapters we consider these important issues.

The contribution of medication to recovery

Medication and choice

In a recovery-focussed mental health service, a full range of psychotropic medication is available. However, the job of the service is not to get medication taken, whatever the cost. The job, of course, is to support personal recovery. This may or may not involve use of medication for an individual at a particular point in their life journey. So medication is one potential recovery support, among many. But prescribing of psychotropic medication is almost universal in current mental health services[208;209;213]. Using medication as a resource to promote personal recovery will require new values, beliefs and working practices.

A shift in beliefs and consequent working practices may be helped by exposure to unbiased empirical evidence about psychopharmacological effectiveness. This was reviewed in Chapter 6, which also identified that people decide not to take their medication for a wide range of reasons. For example, David Whitwell suggests the following causes for non-adherence: loss of autonomy; accepting something of which they disapprove; taking tablets to deal with mental suffering is seen as weak, stupid and superficial; viewing it as being prescribed to shut them up; link with coercion; direct side-effects, toxic effects, stigma, uncertainty about effectiveness[22].

The language of prescribing systematically understates or ignores these diverse and understandable reasons. It euphemises the harm caused by medication as 'side-effects', when these effects may be of central importance in the person's decision-making. It also assumes that normality is a desirable goal, a view that is challenged in many recovery narratives. Peter Chadwick describes the impact of medication as leading to more organised thinking but with less colour and flamboyance in life[67]. Richard McLean describes his life as 'less interesting' on medication[514]. Elyn Saks, a professor of law and psychiatry at University of Southern California, differentiates between medication which kept her alive and psychoanalysis that helped her find a life worth living[515]. Overall, automatically assuming that a decision not to take medication as prescribed is irrational, unhealthy, indicative of impaired insight and not in the person's best interest is a belief that gets in the way of supporting recovery.

New values are needed. For psychiatrists and other prescribers, an embedded current value is that the job is to prescribe – failing to prescribe would be negligent[22]. Since every diagnosis has an associated drug treatment, this need-to-prescribe becomes a permeating assumption applied to all mental health service users. This value creates the context in which a person who decides not to take their medication is labelled as lacking insight and non-compliant. This is an attributional bias, in two ways. It valorises the behaviour negatively (i.e. as a bad thing), when it may be a sign of empowerment, or of rational decision-making about costs and benefits of medication use. It also locates the cause internally to the patient, rather than considering external attributions – 'non-compliant patient' is a more common term than 'ineffective medication' or 'incorrect prescription'.

These attributional biases work against personal recovery. They create the beliefs that taking medication is always a good thing, when it is not. They foster a focus on passive rather than active compliance, by sending the message that just as it is the job of the prescriber to prescribe, it is the job of the patient to take the prescribed medication. Passive compliance is antithetical to personal responsibility.

Clinical responses based on this attributional bias also hinder recovery. Since most clinicians are altruistic people who do not want to treat patients compulsorily, a curious distortion of the more benevolent term 'choice' has occurred in relation to medication. It has sometimes been distorted to mean that patients are given choices, but only within a narrow range of predefined constraints decided by the prescriber: for example, the choice of which of two antipsychotics to take, or whether to have a marginally higher or lower dose. Another distortion is when informed choice is promoted through the use of psychological interventions (e.g. compliance therapy[516]) which use principles from motivational interviewing to improve compliance, i.e. the predefined aim is to get the patient to take the medication, rather than to aid decision-making. Another strategy is providing psychoeducation involving propagation of a biomedical model as if it is uncontested, normally involving the assertion that mental illness is caused by – and therefore necessarily treated by restoration of – neurotransmitter disturbance[239]. The development of approaches to compelling people to take treatment (the euphemism which almost always means medication) is the logical next step, with many countries considering or implementing legislation for compulsory treatment in the community, despite the clear evidence that the approach is at best inadequately researched[517] and at worst ineffective[518]. All these approaches to trying to make people take their medication get in the way of personal recovery; they disempower the patient, they take away responsibility from the individual for their own well-being and they promote passivity and dependence.

It is worth noting that there is an opposite danger. I have spoken to several prescribers who recount narratives of being personally aware of issues with over-prescribing, encouraging patients to reduce or come off medication, and then seeing them rapidly relapse with disastrous consequences. As much skill and partnership with the patient needs to be brought to a decision not to prescribe as to a decision to prescribe.

The job of the clinician is to give genuine choice and control about medication to the service user. This means that the person may decide to use medication as the prescriber recommends, or may modify the recommendations of the prescriber, or may decide not to take medication. Genuine choice is available only where any of these choices is allowable, which is why prescribing levels are a litmus test for a recovery focus[519]. The content of the individual's decision about medication is in a sense irrelevant – what matters is the extent to which the person is taking personal responsibility for their well-being.

Medication and recovery

So what does a recovery-focussed approach to medication look like? Of course, many clinicians will place great importance on medication. Their psychopharmacological expertise may be well-developed. This is an important resource to bring to the decision-making process. The change in a recovery-focussed service is that this expertise is meshed with the consumer's expertise about their own values, beliefs, goals and preferred approaches to meeting challenges. In a partnership relationship, the job of the clinician is to help the person come to the best choice *for them*. The clinician does not know what is the best choice, because they only have half the story. They do not know what is in the person's best

interest (despite the common legal and social expectation of this being a core part of the professional's role). Even if medication always impacted beneficially on symptoms (which it does not), individuals vary widely in the importance they attach to symptom reduction. This is illustrated by a survey of the views of people taking psychotropic medication[268]:

> Without major tranquillisers myself and my family feel I may not have survived, as hyperactivity and starvation led to rapid weight loss as well as psychological symptoms.
>
> The drugs block out most of the damaging voices and delusions and keep my mood stable.
>
> Injections seem to dampen down the voices. They decrease the voices but not altogether, and the side effects are unpleasant.
>
> They do not cure the cause of conditions; they have the side effects of making you unnaturally doped, enormously fat.
>
> With major tranquillisers, I feel as if I'm in a trance. I don't feel like myself.

Medication may or may not be necessary for recovery – the journey of recovery involves finding out whether it has a part to play. Since medication will be a tool for many people, at points in their life, it is often important to discuss. The discussion needs to focus on what will be helpful for the individual, and in order to have that discussion the first thing that needs clarifying is the person's recovery goals. Once it is clear what the person is trying to achieve in life, then the role of medication can be discussed in a more focussed way. Some people will want to be prescribed medication, and it should be fully available. Some people will experience decisional uncertainty, and the clinical task is then to support decision-making through crystallising questions, providing unbiased information and supporting the person to plan and undertake experiments. This will involve truly shared decision-making – two experts in the room, jointly undertaking information exchange and (always) clarification of values. Decisions about medication, just like any other form of treatment, are personal not medical decisions.

How is this done? This is an area where mental health services can learn from innovative approaches to supporting the decision-making process in general medicine (e.g. www.dhmc.org/shared_decision_making.cfm, http://decisionaid.ohri.ca/odsf.html). Some of these decision-support approaches are now being evaluated in mental health services, e.g. CommonGround[520]. One such approach is to reframe medicine – in the sense of things that help you to feel better – as much more than solely pharmacological. Pat Deegan's notion of personal medicine[521] includes all the things that people do to feel better: laughter, love, hope, caffeine, exercise, chocolate, etc. In other words, medicine is what you do, not just what you take. Pill medicine (i.e. psychotropic prescribed medication) is then a sub-set of personal medicine. This approach is of course already used, such as when prescribing exercise[522], nutrition therapy[523] or bibliotherapy[524]. This has two implications. First, the prescriber is not the arbiter of the best medicine – only the consumer can judge what medicines are helpful. This is facilitated by the development of what Deegan calls power statements which reflect the person's goals for using psychiatric medication[525]:

> For example, a husband developed the following power statement to share with his psychiatrist:
>
> My marriage is powerful personal medicine, and is the most important thing in my life. I don't want paranoia or sexual side effects from medication to stress my marriage. You and I have to find a medication that supports me in my marriage so that my marriage can support my recovery.

Notice how the power statement contextualizes the use of medication within the overarching goal for recovery. Also, notice how the power statement acts as an invitation to collaboration and shared decision-making between the prescriber and the client.

(p. 67)

Second, it highlights that finding the balance between pill medicine and other forms of personal medicine is central. If the most important medicine *to the individual* is pill medicine, then a focus on medication is appropriate. If, by contrast, the most important medicine (i.e. what gets and keeps the person well) is some other form of personal medicine, then a focus on psychopharmacology will hinder recovery. The medication trap occurs where the focus on pill medicine inadvertently undermines the person's efforts to find their own personal medicine. Finding a balance between personal medicine and pill medicine is an essential ingredient of recovery.

For some people, pill medicine becomes a central issue. In a recovery-focussed service, there is an orientation towards supporting the person to take responsibility for their own lives. One implication is that people will be supported to come off medication. This of course will involve the normal approaches of giving expert information from a clinical perspective about advantages and disadvantages. It will also involve identifying alternatives – continuing with medication for a fixed period and then re-reviewing, identifying early warning signs and joint crisis plans before stopping, graded withdrawal, etc. However, it will also involve giving primacy to the individual's wishes, by validating their decision even where it differs from the prescriber's view. The work then is to support the person to plan ahead, and to identify alternative sources of support. This requires a partnership relationship, in which taking responsibility for one's life is viewed as more important than taking prescribed medication. Both prescribers and consumers will benefit from exposure to the resources which are becoming available to support people who want to come off their psychiatric medication, including web-sites (e.g. www.comingoff.com), booklets published by voluntary sector groups[526;527] and books[528–530].

A recovery-promoting approach is thus to view medication as an 'exchangeable protection against relapse'[531], in which pharmacological and psychosocial approaches both buffer the individual against relapse. For example, framing medication as a potential tool for sustaining well-being creates a very different dialogue[351]. The advantage of this view is that it creates a focus on promoting resilience (which definitely matters) rather than on medication (which may or may not matter). Resilience can be supported by working with the consumer to identify answers to the statements 'I have . . .' (external supports of people and resources), 'I am . . .' (inner personal strengths) and 'I can . . .' (social and interpersonal skills)[292]. (See www.resilnet.uiuc.edu for more on resilience.) Medication is thus one potential external support, alongside a whole range of other types of resilience-promoting supports, skills and strengths.

The contribution of risk-taking to recovery

An important clinical issue raised by a shift towards individuals having responsibility for, and control over, their own lives is risk. What if the person chooses to do things which are a danger to themselves, and hence create anxiety in the clinician? At present, the tension is often resolved by reducing clinical anxiety, as noted by Glenn Roberts:

> Deegan's rallying call that 'professionals must embrace the concept of the dignity of risk, and the right to failure if they are to be supportive of us'[474] seems completely at odds with the risk-averse climate in which we live and work, where, for instance, patients may have to be medically vetted before an occupational therapist can take them for a cycle ride.[466]
>
> (p. 28)

As well as risk of harm to self, there is a high expectation on mental health services that they will manage risk to other people. Clinical language has evolved to support this demand. Concepts such as *medical responsibility*, *clinical responsibility*, *best interests* and *under the care of* all support the belief that it is possible for mental health services to be responsible for the lives of others. The personal and professional consequences of tragedies on clinicians are also highly aversive, such as being questioned in the coroner's court to identify whether everything that could be done was done (who can really meet that threshold?) to save someone's life, or being pilloried for poor practice in the media or by public enquiries following a high-profile homicide.

This political and professional reality influences the mental health system towards risk avoidance. Does this matter?

Two types of risk

A focus on risk avoidance matters because people need to take risks to grow, develop and change. In everyday language, taking risks is a necessary part of being human. The conflation of these two uses of the term risk – something necessary and something to avoid – is unhelpful. In a recovery-focussed service, there is a clear separation of the two meanings.

Harmful risk relates to behaviours which are illegal or not socially sanctioned. Into these categories fall homicidal and suicidal acts, anti-social and criminal behaviour (such as assault, aggressive begging and theft), personal irresponsibility (such as out-of-character promiscuity or financial profligacy), self-harming patterns of behaviour (such as violent partner choice or self-neglect) and relapse of mental illness. (Note that in Chapter 2 we discussed the potential positive aspects of mental illness, but here assume that relapse of mental illness is undesirable for most people.) Harmful risk is to be avoided. Treatment goals focus on reducing harmful risk. Avoidance of harmful risk can also be part of a recovery goal, although this is avoidance for a reason: 'My marriage means such a lot to me that I want to avoid threatening it through sexually disinhibited behaviour when I am unwell'.

Positive risk-taking relates to behaviours which involve the person taking on challenges leading to personal growth and development. This includes developing new interests, trying something you're not sure you can achieve, deciding to act differently in a relationship, and developing and consolidating a positive identity. There is nearly always benefit from this – even if it all goes wrong, the learning is valuable. Resilience is developed through trying and failing – whether it be the common things like dating, employment, sex and religion, or the idiosyncratic things like singing, archery, political activism or dress, we all learn from mistakes. People with mental illness are (of course!) no different. Positive risk-taking – risk for a reason – will be needed to meet many recovery goals.

Recovery-focussed services are mindful of several issues in relation to risk. First, this is a political as well as scientific domain. A recent review concluded that the lifetime prevalence of violent behaviour (defined as use of a weapon such as a knife or gun in a fight and engaging in more than one fight that came to blows) is 16% in people with severe mental illness, compared with a population prevalence level of 7%[532]. The low base rate of severe mental illness means the attributable risk is only 3–5%. The same study concluded that the lifetime prevalence of violent behaviour among people who abuse drugs or alcohol is 35%, and in those with comorbid mental illness and substance abuse is 44%. There are also risk factors for injury which have much higher base rates, such as driving with two or more passengers (Odds Ratio 2.2, 95%CI 1.3–3.8) or using a mobile phone whilst driving (OR 4.1, 95%CI 2.2–7.7)[533]. Singling out people with mental illness for special risk management attention is not the actuarial place to start, but the logical places – such as pubs and the school run – are not politically acceptable targets. Risk management in mental health services is discriminatory.

Second, disinterested scientific enquiry is difficult in this domain. The part of the academic system which is most focussed on the issue – forensic mental health – has (as a statement of fact rather than as a judgement) a vested interest in finding higher levels of harmful risk to others. Research from this perspective inevitably amplifies the link. This is not because of fraud, but because researchers tend to find more of what they are looking for than what they are not looking for. Studies by geneticists amplify the extent of genetic influences on behaviour. Research by psychologists amplifies the impact of intrapsychic influences, etc. Coupled with biased media portrayals[534;535], this can create a highly distorted picture. Unfortunately, some professionals reinforce this distortion: the person dubbed by the *Washington Post* as 'the most famous psychiatrist in America' writes that[536]: 'the typical citizen is well aware that untreated mentally-ill individuals can be dangerous, whether professionals want to speak about it or not. All he need do is open his morning paper.' The belief that schizophrenia is a chronic deteriorating condition was only challenged when individuals and more recently research studies began appearing which provided a weight of evidence that recovery is possible. There is no equivalent expert group with a vested interest in finding lower levels of harmful risk to others, who could provide an academic counter-balance to this tendency towards amplifying the link. Consumer-led research may be one future correcting influence[537].

Third, the goal of eliminating harmful risk is both an illusion and damaging. It is an illusion stemming from the technical rationality and Apollonian views of the world outlined in Chapter 4. The underpinning assumption is that if we had the right risk assessment and management technologies, and the right clinical guidelines and rules, we could stop tragedies from happening. In fact, the only definitive trial ($n=1445$) of schizophrenia treatment examining community violence as an outcome showed very modest results: under intention-to-treat analysis violence across all treatment groups declined from 19% to 14%,

but no difference by medication was found[538]. Because risk cannot in fact be eliminated, the danger is that the endless quest to manage risk consumes an ever-greater proportion of clinical resources. Focussing on harmful risks creates the same issue as the approach of treating until well and only then getting on with life. It fosters a cycle of disengagement (because the service is focussed on what it thinks matters, rather than what the person thinks matters) and compulsory intervention (to reduce risk). Inadvertently, this can be a feature in services which aim to provide highest-quality care. Detailed assessment processes involving consideration of multiple components of risk meet the clinical need for best practice, but the message they can inadvertently send is that they are there to stop the person from doing things, rather than support the person towards a better life. Engagement with, and productive use of, mental health services is much more likely if recovery goals rather than treatment goals are given primacy.

Fourth, a clinical emphasis on risk management can be unintentionally counter-productive, by reducing skills in risk self-management. People (whether they have mental illness or not) avoid acting on harmful impulses because they have valued social roles they don't want to jeopardise, a positive identity they don't want to threaten, and the ability to recognise and self-regulate emotions and their behavioural sequelae. A focus on avoidance of harmful risk through action by clinicians creates a culture which may in fact *reduce* the extent to which people develop skills at taking responsibility for their own actions.

Fifth, any approach to risk needs to be organisationally mandated, with responsibility held by the service rather than the individual worker. Defensive practice is inevitable if consumer choice equates to clinician risk. A realistic professional concern is that, despite the rhetoric, if a tragedy happens involving a patient being seen by mental health services, the individual clinician will be blamed[466]: 'Clinicians may wonder whether, when things go wrong, the principle of risk-sharing will extend to the trust board, and it may be a wise early step to seek endorsement from senior management in developing recovery-based services where choice and risk are significant issues' (p. 33).

Finally, risk management involves power, and so is an ethical issue. Most mental health services have expertise in managing this ethical tension, but focussing on recovery will make this tension more explicit. The person who is not actively trying to do anything poses fewer ethical dilemmas than the person who is striving towards recovery goals. For example, a client at a service which was attempting to implement the Strengths Model[72] identified riding a motorbike as a personal goal. This new skill clearly had the potential for personal growth, but also raised clinical anxiety, since the client was on high-dose anti-psychotic medication and had a long history of symptoms of schizophrenia. If the service had given primacy to avoiding harmful risk, the client probably would not now be running a motorbike group for other consumers. A recovery-focussed mental health service must be prepared to experience this uncomfortable tension, which in increasingly litigious societies may be especially anxiety-provoking.

A recovery-supporting approach to risk

Taking all these issues into account, some features of a recovery-focussed approach to risk management can be identified:

- Audited and organisationally supported systems are used to assess, develop and document actions focussed on reducing harmful risk. The consumer understands that these treatment goals are necessary for the professional – it is not *necessarily* done for the consumer. The development of treatment goals is led by the professional

- Audited and organisationally supported systems are used to assess, develop and document actions involving positive risk-taking in the service of recovery goals. The professional understands that this is about the recovery goals of the consumer – it is not *necessarily* agreed with by the professional. The development of recovery goals is led by the client

- There is a greater focus on positive risk-taking than on avoiding harmful risk, because this is what develops risk self-management skills

- Actions to reduce harmful risks are as far as possible decided collaboratively with the consumer. Differences are discussed openly, and where treatment goals need to be set because of the level of risk, this is acknowledged and explained, and a consensual middle ground sought

- Clinical decisions are where possible made by multiprofessional teams rather than individual clinicians. This allows for distributed responsibility for decision-making rather than anxiety being held by an individual worker.

A balanced approach values both minimising harmful risks and maximising creation of positive learning opportunities. In terms of the tension between what the person and the clinician wants, the challenge is clear[491]:

> Providers need to learn to comfortably exist in a 'conflict zone' somewhere between unacceptable provider control and unacceptable risk by the individual and family. Objectives need to be selected with awareness of and sensitivity to this underlying dynamic. Most individuals learn and grow from taking risks and learning from both their successes and failures . . . individuals and families on the road to recovery should not be unreasonably denied the same opportunities.
>
> (p. 150)

This balance is embedded in the approach to enhancing autonomy rather than creating dependency which is described in our next case study. The aim of the Strengths Model is to help people to achieve the goals they set for themselves, by moving from a deficit-based to a strengths-based approach to care[72].

Case study 13: the Strengths Model

The Strengths Model is being implemented in the adult rehabilitation and continuing care services at St Vincent's Mental Health statutory sector services in Melbourne, Victoria. The service uses three care-planning types of document:

1. **Professional treatment plan**

   This outlines treatment goals, with a particular focus on medication, psychological treatments, early warning signs and risk – akin to a treatment plan in a traditional mental health service. It is written by the case manager, in collaboration where possible with the consumer. It incorporates the early warning signs elements from WRAP[351]. The advantages of separating treatment plans from goals are (i) it makes more explicit the clinical responsibilities of the case manager – the treatment plan is a component of care, but not the main work; and (ii) it allows a more transparent negotiation about clinical versus client priorities.

2. **Strengths assessment**

   This identifies the person's strengths and current situation – What's going on today, what can I do now, what has worked for me in the past? The assessment requires new skills in clinicians, as they learn how to move from a deficit-focussed mental state examination to skills

Case study 13: (*cont.*)

in systematically identifying strengths. Assessment includes previously ignored areas, such as spiritual well-being. The process leads to shifts in attitude, from 'mental patient' to 'struggling and engaged person'.

3. **Goal plan**

This is led by the consumer and co-written with the case manager. It uses the individual consumer's unique journey of recovery as a springboard to identify goals, and to establish an agenda for the work with the case manager. The goals may be short-term stepping-stones (who will do what, by when) or longer-term goals – a personal vision or dream for the future. An important value is that all goals are recorded, regardless of whether they are 'realistic'. This is a value because it communicates that it is wrong for professionals to decide what is realistic. Goals set and attained by clients, who are all long-term users of the service, include riding a motorbike, going fishing, gaining a fork-lift truck licence and obtaining employment.

Workers in the service identify the following changes arising from the change in model:

- **Expectations** – from the modest (and often impoverished, such as 'maintenance') expectations of treatment to big dreams and 'audacious' goals
- **Planning** – from the case manager driving the plan to the consumer as the director of their own life
- **Anxiety in the consumer** – taking control of their own life can be scary and initially undesirable. The intention is that this anxiety reduces with increasing self-efficacy and self-esteem
- **Anxiety in the case manager** – empowering the consumer raises anxieties about risk. The intention is that experiencing the consumer as the director of their own life reduces the case manager's anxiety, as they learn that they cannot be responsible for the person's life
- **New ways of talking** – the clinical discourse is less negative and more sophisticated, seeing the person in the round rather than through a deficits filter. The content is more developmental and community-focussed, with fewer implicit expectations of mental health care always being needed. There is less use of black humour (the euphemism for prejudicial views) – pejorative casenote descriptions such as 'WOO' (Waste Of Oxygen) are no longer tolerated
- **New ways of being** – different ways of working with the consumer are needed, which change the implicit power structures and approaches to relating, e.g. 'moving from an interrogation mode to a conversational mode'[72] (p. 119)
- **Medication** – from being a high priority for the case manager to a more negotiated part of the support package
- **Risk** – from being a central element of the (only) treatment plan to being more obviously a care manager – rather than consumer – priority
- **Service links** – from a primary focus on other mental health and social care services to a focus on mainstream community services.

Change is sustained in several ways. For example, group supervision involves all case managers (i.e. no service managers or psychiatrists), with an expectation of attendance. The content is goal-directed, focussed on strengths and intended to inform the assessment and goal-planning processes. The facilitator is called a strengths supervisor, and their role is to support participants to make the transition from seeing deficits to seeing strengths in the client. Other change approaches include local leadership, ongoing involvement from an external expert site (see Case study 23), regular audit and formal and informal consumer feedback.

Further information: Bridget Hamilton (Bridget.hamilton@svmh.org.au)

Risk is best addressed proactively. Lines of behaviour crossed once are more easily crossed again, and stress is more easily contained if diverted rather than allowed to grow to crisis point. From a recovery perspective, this means that harmful risks are reduced by: (i) harnessing motivation through focussing on approach rather than avoidance motivation; (ii) amplifying rather than minimising risk self-management skills, and (iii) intervening early. The development of recovery goals which involve positive risk-taking may therefore, paradoxically, reduce harmful risk. They give someone a reason not to self-harm or self-neglect or be violent. Focussing on strengths creates possibilities, rather than focussing on illness deficits, which creates a compliance and passivity context in which the anger of disenfranchisement and disempowerment are more likely.

We turn now to the sharp end of the mental health system: how to work with people in crisis.

Recovery through crisis

Language is important. The experiences that professionals might understand as relapse are referred to here as crisis. The advantage of this more neutral term is that it avoids the assumption that the experience has to be understood in illness terms. A recurrence of psychotic symptoms can follow from interpersonal conflict, work problems, loss of housing, existential or spiritual crises, decisions about medication, loss of natural supports, unhelpful behavioural responses, self-medicating with alcohol or cannabis, and many other reasons. Labelling the experience as a relapse orients clinical attention towards symptom reduction, rather than the bigger picture of the person. Labelling as a crisis has more helpful connotations, in which the experience also has potential to be a learning opportunity, or a turning point.

Compulsion

Compulsion during crisis is sometimes necessary in recovery-focussed mental health services. For someone who is unable to take personal responsibility for their lives, and consequently at risk of harming themselves or others, their views are temporarily subordinated to wider societal values. **A focus on personal recovery is not a charter to stand back and let tragedies happen because the person didn't ask for or want help.** So compulsion during crisis is acceptable, if other options have been exhausted.

The traditional service response to a person presenting in crisis has been hospitalisation. However, many people experience admission negatively[201]. For example, in the UK a survey of 343 people who had experienced an admission found 45% reported a negative effect on their mental health, compared with 27% reporting a positive effect[539]. Only 18% of respondents reported talking to staff for more than 15 minutes per day. When asked what help is needed in a crisis, only 2% of 401 UK service users identified hospital admission[540]. The situation is no different in other countries. A US survey concluded[541]:'Participants reported that [hospital] settings cause them to lose their living skills, and re-traumatise them. The lack of access to the outside world gives a sense of being a citizen and a community member.' In New Zealand, services are similarly characterised[295]: 'The main interventions in acute units are medication and containment. Many people are there under the Mental Health Act and the vast majority are on medication. Typically, there are few other treatments or services available to people' (p. 9).

Traditional acute in-patient units are particularly challenging settings for a recovery focus because:

- they are often located within institutions, with consequent organisational and professional resistance to change
- there is a historical expectation of compulsion and a subordination of the wishes of the patient to the overarching aim of risk management
- the oppressive and counter-therapeutic atmosphere of many in-patient units and the use of chemical or physical restraints to ensure safety are in themselves traumatising

- the person is removed from their context, and illness-related behaviour is prominent, leading to deindividuation and a negative bias (described in Chapter 2).

This has long-term effects – over a third of people with mental illness report avoiding mental health services because of fear of coercion[542].

On the other hand, the capacity for psychiatric rescue through the ability to make clear plans along with the authority to carry them out is a major strength of mental health services. The system is a better safety net than any currently available widespread alternative. Receiving mental health care during a crisis is better than receiving nothing, and better than being dealt with by the criminal justice system.

Whilst hospital may be a good safety net, the challenge is to make the net springy rather than saggy. Consumers report a 'lack of springiness in the net to allow me to get back on the tightrope'[143]. As Glenn Roberts put it[466]: 'Service users want rapid access to help in a crisis, but once it has resolved they do not necessarily wish to be caught up in long-term involvement and monitoring, however well intentioned' (p. 30). The key challenge is creating the springiness in the safety net. What would a recovery-focussed in-patient service then look like? An overview is provided by the New Zealand Mental Health Commission, which mapped candidate elements[295] shown in Box 21.1.

Box 21.1 Features of a recovery-focussed in-patient service

1. A safe normalising environment
An open-door policy, a home-like environment, and containing fewer than 15 people. Avoiding admission where possible: 'while general hospitals may be well located in the community, they still represent a symbolic exit from community life' [295] (p. 15).

2. Recovery values
A shift from segregation to social inclusion, from paternalism to self-determination, and from 'the dominance of medical approaches . . . to more holistic approaches' (p. 15). Crisis is not only a time of risk, but an opportunity for personal growth.

3. Egalitarian culture
Power structures are different, with more mingling between staff and patients. Talking, negotiating and self-responsibility are emphasised. Participatory approaches to decision-making dominate, rather than authoritative approaches to control.

4. A well-matched mix of people
The service is responsive to the cultural and developmental needs of the individual. This means recognising, for example, that a unit catering predominantly for the needs of a group of older adults with chronic mental illness may *in itself* be traumatising for a young person experiencing a first episode of psychosis[125]. A wide range of accessible staff from health and other backgrounds (e.g. peer support workers, chaplains)

5. A broad range of competencies
Both pharmacological and psychosocial expertise are available to all in-patients. A focus remains on encouraging and amplifying self-directedness and self-advocacy, rather than 'being compelled into dependency and compliance or resorting to rebellion' (p. 16).

6. A broad range of interventions
Available forms of support include medication, complementary treatments such as homeopathy, physical treatments such as massage, self-help approaches and psychosocial approaches such as counselling, practical assistance, peer support or therapeutic communities.

The orientation in recovery-focussed mental health services is towards avoiding unnecessary crises and responding helpfully to crises when they do occur. What does this involve? A recovery-focussed approach to crisis has four aims:

(i)   to prevent unnecessary crises;
(ii) to minimise the loss of personal responsibility during crisis;
(iii) to maintain hope during crisis;
(iv) to support identity in and beyond the crisis.

We now consider each aim.

Preventing unnecessary crises

The best way of reducing the likelihood of a crisis is through the development of self-management skills. These lead to agency, empowerment and the resilience to cope with set-backs. The general approach to supporting self-management skills was described in Chapter 18. An important type of self-management skill is the ability to recognise and respond to the symptoms of mental illness.

Early warning signs work supports the person experiencing psychosis to identify their relapse signature[543] – the general and idiosyncratic symptoms which occur in a specific order over a particular period, and for that individual are indicative of impending psychotic relapse. The approach aims to develop a collaborative relationship, to enhance self-management skills and to predict relapse. The fortnightly use of standardised symptom measures can predict psychotic relapse with a sensitivity of 50–79% and a specificity of 75–81%[544], and higher if more individual changes are also considered. This mirrors the finding that regular assessment using standardised measures reduces hospitalisation[545]. The challenge in relation to recovery is to undertake early warning signs work in a way which enhances the person's ability to self-right, rather than creating anxiety about, and over-vigilance for, relapse. Clinical skills are needed to communicate two things to the consumer.

First, not all of life's bumps are indicators of potential relapse. Difficult feelings like anger, hurt, suspicion and guilt can be psychologically healthy responses, and not necessarily an indicator of impending relapse. Furthermore, everyone has good and bad days – and the goal is to create a virtuous cycle by recognising strengths and achievements, rather than a vicious cycle of hyper-vigilance to prodromal symptoms. At least as much clinical effort needs to go into the promotion of self-efficacy and flourishing, orientations which equip the person with the skills to engage in life and an attitude of being able to deal with (rather than avoid) adversity. This is like the difference between learning to stand still so as to avoid falling over, and learning how to get up after a fall. Life is a lot more fun when movement is possible!

Second, relapse, in the sense of going backwards, is normal. People struggling to break free from previous behaviour or emotional patterns experience set-backs. It may be helpful to communicate that most abstinent smokers have made 12–14 previous quit attempts[546], or that most millionaires have experienced bankruptcy or near-bankruptcy 3.2 times[547]. Set-backs are normal and necessary in life – they are a sign of health, not illness. The response to these set-backs is the critical factor. It is to the role of mental health services during this part of a person's life that we now turn.

Minimising the loss of personal responsibility during crisis

The orientation in a recovery-focussed service is towards making as few decisions for the person as possible. Services and treatment processes are geared towards minimising the impact of the crisis on hope and the consumer's ability to take responsibility in the future.

This is done by keeping the process of decision-making as close to the person as possible. Ideally, people make their own decisions. Where they have temporarily lost this ability, their previously elicited views are used, or proxy decision-makers make decisions on their behalf. Only where these avenues are not available can it be justified for a clinician to make decisions in the person's best interests.

A key approach to reducing loss of autonomy is therefore the use of advance directives. These allow people to express in advance their preferences for what they want to happen during a future crisis. They are designed for people with psychiatric or other disabilities who anticipate periods of decisional incapacity associated with symptom exacerbation. They can take many forms[548], but broadly fall into two categories: advance instructions including statements of acceptance or rejection of certain treatments, and identification of a proxy decision-maker to make decisions on the person's behalf[549]. The legal standing of advance directives varies by country, but for example in the USA there is related legislation in most states[550], and developing interest in New Zealand (www.mhc.govt.nz). In England and Wales, the Mental Capacity Act (2005) requires consideration of 'the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)'.

Advance directives reduce rates of compulsory hospitalisation[503], and are popular with consumers[551;552]. Although only between 4% and 13% of individuals in a large ($n=1000$) US study had an advance directive, between 70% and 83% were interested in one if they had support[553]. Advance directives offer many pro-recovery features, including self-direction, empowerment, strengths-based assessment and promoting respect for the individual's wishes[554]: 'You know what the doctor said to me? [He said] "You've got rights and it's great that you know you have them . . . Now you know your rights and we'll try to respect those completely"' (p. 72). Greater use of peer-led interventions to support individuals to complete and use advance directives has been suggested[554], building on evaluations of peer-led approaches in New York[552] and Washington[555].

Clinicians hold mixed views about advance directives. Identified barriers include the intrinsic complexity (e.g. legal language, finding witnesses, filing with providers) and the systemic barriers impacting on provider access to the advance directive when the person presents in crisis[554;556]. They also note (and perhaps this is the real issue) the ethical dilemma of being asked to follow the advance directive if they do not perceive this as in the person's best interest[557;558]. In a recovery-focussed mental health service, advance directives are not something that get in the way of providing good-quality crisis care. They are routinely developed and acted on precisely because **advance directives give the information the clinician needs to do their job – which is keeping the person and their values centre-stage during crisis**.

Advance directives are what makes a partnership relationship possible during crisis. Therefore they need to be a joint undertaking, in which the consumer educates the clinician about their preferences, and the clinician provides empirical, ethical and procedural information to inform the consumer's decision-making. If there is disagreement between the clinician and patient perspectives, then it is clearly better discussed in advance than when in crisis.

Other approaches to reducing the likelihood of disempowerment during crisis include shared care agreements[559] and patient-held records[560]. What these approaches all have in common is that there is randomised controlled trial evidence to support their use, and they all orient the individual towards taking responsibility for their own lives and what happens to them in crisis.

A central challenge for mental health services is recognising when treatment is helping and when it is hindering. In a crisis situation, the job of services may be to hold people up (in the supportive sense). During the rest of the person's life, the job of services is to avoid holding people up (in the constraining sense). This balance involves constantly maximising self-determination. A key element of self-determination is the ability to state preferences and for those choices to be honoured by mental health services in times of crisis or hospitalisation[561]. An explicit focus on self-determination is important[333]: 'Because it is the individual with the psychiatric disability who recovers, it is this person who must direct his or her own goals by identifying a life path and determining desired steps to take along that path, choosing from various options and designing a unique life journey' (p. 11).

Once the person is in crisis, how can services respond in a way which minimises loss of autonomy? A change is needed in relation to the construct of capacity. Like other apparently binary concepts such as insight and compliance, it is often used as if it is unidimensional and discontinuous. A more nuanced view of capacity as multidimensional and continuous has the advantage of pointing to a goal of maximising what the person can decide for themselves during crisis. Being involved in apparently small day-to-day decisions can provide a way of sustaining the personal responsibility muscle during crisis. There are many domains in which even people who are compulsorily detained and treated can take responsibility, such as food, activities, personal hygiene, keeping their bedroom clean and tidy, etc. This is of course difficult for people in crisis – which is exactly where skilled professionals can be a great support, when they are oriented away from a doing-to style of working and towards doing things with the person and supporting the person to do things for themselves. Reinforcing success, e.g. through praise for getting up when this is a struggle, is an important intervention.

If, as we have argued, hope is vital for recovery, how can hope be maintained when in crisis?

Maintaining hope during crisis

We noted in Chapter 3 that hope is a problem for mental health services. Maintaining hope in a crisis is even more difficult, because the clinician's illusion makes it difficult to see crisis as an exception rather than the norm[323]. For clinicians who work only with people in crisis, this illusion expresses itself in two ways:

(a) If the clinician only sees people with a diagnosis of schizophrenia when they are in crisis, then the available evidence will suggest that schizophrenia is always associated with high levels of distressing, disabling and unmanageable symptoms. This provides a context in which symptom-oriented rather than person-centred treatment flourishes. Addressing this aspect involves exposing the clinician to people with a diagnosis of schizophrenia who are not in crisis, either by bringing role models into the crisis setting or taking the clinician out (e.g. by rotating between crisis and community work settings)

(b) If the clinician only sees an individual during crisis, then it is difficult not to form a view that this is how they are all the time, leading to therapeutic pessimism, and a decontextualised understanding of the person which underestimates their strengths and normal self-management skills. In Chapter 16 we identified time-lines as one approach to putting the crisis into a temporal context. Another approach is for clinicians to work with an individual both during crisis and during the rest of their life, rather than having separate crisis teams (see Case study 25).

A key resource is the experience of peers, and a peer-run residential crisis service is described in the next case study.