Recovery task 4: developing valued social roles

The final recovery task involves the acquisition of previous, modified or new valued social roles. This normally involves social roles which have nothing to do with mental illness. The exception to this is the consumer activist, who uses their own experiences of mental illness as a springboard to working in mental health services (see Chapter 12) or to social activism (see Chapter 23). Valued social roles provide scaffolding for the emerging identity of recovering person.

This process overlaps with the development of a positive identity, but differs in two ways:

1. It is about who I am to others and in the world, rather than who I am to me. The focus is on identities which are created and maintained in the world – which will tend to be social rather than personal identities

2. It is about the development of scaffolding that supports the positive identity, by providing a rich and layered identity in which no one element (such as '*I am mentally well*') is the only element that really matters. It also creates fall-back positions to deal with identity challenge – '*Well, if I'm not in work, at least I can do more painting*'.

What is a *valued* social role? Like identity, it comprises two parts – personal and social value. A person may feel good about themselves (personal value) for having shown the determination to create a role as an independent thinker, even if others do not seem to value this role. Alternatively, someone may enjoy the social status of their job (social value), even if they do not personally see the job as very important. Social roles which are valued by both the person and their environment are the easiest to maintain, as they are reinforced both individually and socially.

Identity and relationships

All four recovery tasks involve relationships, because identity involves relationships – either with ourselves (personal identity) or with the world and other people in it (social identity). This is consistent with the emphasis put on relationships in the accounts of people who have experienced recovery from mental illness. Why are relationships so vital?

The earlier description of identity was informed by Erik Erikson's theory of psychosocial development[335] and George Kelly's personal construct theory[77]. Both theories emphasise the importance of social interaction in negotiating and defining a sense of identity[336]. Current identity research suggests that identity formation and maintenance is a more active process than Erikson envisaged, involving continuous creation, challenge and re-creation[337]. Identity is not a fixed construct, but consists of a configuration of *possible selves*[338] or self-constructs. Key possible selves are the feared self (the self we are afraid of becoming) and the ideal self (the self we would like to become)[339]. Two relevant findings emerge from identity research.

First, the primacy and influence of these various past, present and future selves is influenced by social interactions. For example, highly valorised previous identities can influence the social identity of the person for the rest of their life, including both positively valorised identities (e.g. astronaut, popular politician, Olympic gold medal winner) and negatively valorised identities (e.g. murderer, paedophile). But so can present identity over-ride even highly valorised previous identities: Ronald Reagan is not primarily remembered as an actor. So identities can change, and are influenced by the social environment.

Second, the ideal or hoped-for self is a key motivator for action and change. For example, Dunkel and Anthis[340] examined the relationship between hoped-for or feared-for selves and *identity commitment*[341] – level of personal commitment to achieving and maintaining the identity. They found a positive relationship between identity commitment

and consistency of hoped-for positive selves, such as happiness, healthiness and job satisfaction. This relationship was not present between identity commitment and feared selves, such as loneliness, poverty and terminal illness. The hoped-for self is consistent with the ideal self in intentional change theory[339], and can act as goals for the individual. Feared-for selves create negative emotions, reduce motivation and limit the ability to identify and work towards an ideal self. The practical implication is that focussing on strengths and hoped-for selves is more likely to foster positive affect, future orientation and change than focussing on deficits and feared-for selves (e.g. by discourse centred on symptoms and prevention of relapse and hospitalisation)[342].

Relationships are therefore central to identity development, for two reasons: they provide the context in which different possible selves emerge and are reinforced or constrained, and they provide a means of fostering change through focussing on hoped-for rather than feared-for identities.

The emphasis in academic theory on the link between relationships and identity is concordant with the reports of people who have recovered from mental illness. Developing a positive identity involves the relationship with self:

> In the early stages I thought that the answers to my personal recovery lay outside of me. But now I see recovery more as a personal journey of discovery and I am much better at trusting my own instincts and paying attention to feelings instead of suppressing or trying to contain them.[55]
>
> (p. 32)

> One of the elements that makes recovery possible is the regaining of one's belief in oneself.[343]
>
> (p. 9)

Framing and self-managing the 'mental illness' involves the relationship with the illness:

> Me. That's what's changed! Me! It was a control thing. For 20 years there was an unconscious release of control on my part . . . I let the symptoms of my illness become the centre of my universe, and I realise now that the symptoms of my illness are not the centre of my universe.[55]
>
> (p. 6)

> In the early 1980s I was diagnosed as schizophrenic . . . In 1993 I gave up being schizophrenic and decided to be Ron Coleman. Giving up being a schizophrenic is not an easy thing to do, for it means taking back responsibility for yourself, it means that you can no longer blame your illness for your actions . . . but more important, it means that you stop being a victim of your experience and start being the owner of your experience.[116]

Developing valued social roles involves the relationship with the world and those in it. External relationships which are vitally important to one person may be far less significant to another, so it is not possible to create a universally applicable list. However, four types of relationships often feature in stories of recovery:

1. Relationship with a higher being (e.g. spirituality) or connection with others (e.g. culture, society)

> My wife was sitting in the car with me. And I asked her to pray for me and I was just kind of out of control and I was very intense. And, um, so she just laid hands on me and started to pray and I just had a sense that this, yeah, this anxiety went through the top of my head . . . and it, uh, just kind of went to nothing.[107]
>
> (p. 52)

I admitted I was wrong and that was the key to my changing. I was wrong. When I thought about it, this repentance I talked about, I collapsed in the shower. I said . . . 'I'm sorry' to God, 'My life is not what you intended. It could not have been'. So things changed from then on.[107]

(p. 53)

One of the major things for me since my recovery started was feeling integrated and part of the wider community, society, or whatever you want to call it . . . Recovery for me is a discovery of self, or an ongoing spiritual journey to find who you really are.[55]

(pp. 50–51)

2. Close relationships (with partner, spouse, family, friends, neighbours, pets)

I couldn't do what I do every day if it wasn't for my partner . . . She knows that I can do it. Nobody had ever done that for me before, they always wanted to change me or change something, but she likes me the way I am.[55]

(p. 11)

They [my family] were giving me the space but they expected me to come back . . . It was like a grieving time, it really was, you've had your time to grieve, you have responsibilities that require you to see to them, come back and do it![107]

(p. 51)

The hospital was very close to my home and that was very helpful. I couldn't be in my flat on my own to begin with, but I have a cat I wanted to take care of. Pretty soon I had to go there twice a day, morning and evening, whether I liked it or not. So looking after my cat was a major factor in my making my first steps towards recovery.[55]

(p. 44)

3. Relationship with other mental health service users

A person does not have to be 'fully recovered' to serve as a role model. Very often a person who is only a few 'steps' ahead of another person can be more effective than one whose achievements seem overly impressive and distanced.[119]

I realised, sitting there in the acute ward . . . amongst all the other loonies in there, I actually felt safe and comfortable, first time in my life that I could remember.[107]

(p. 54)

4. Relationship with a specific mental health professional

The turning point in my life was . . . where I started to get hope that I could actually make the leap from being sick to being well . . . Dr Charles believed I could. And Rev. Goodwin believed that I could . . . Certain people believed that I could make the leap. And held that belief even when I didn't believe it myself.[344]

. . . it may have been because [my nurse] really seemed to pay a lot of particular attention to me . . . she knew I had potential and talent and all this and that I could get better, and I knew it too.[121]

My relationship over this time with my social worker has been the key thing for me. I began to realise that there were people who believed that there was more to me than my mental health.[55]

(p. 26)

The Personal Recovery Framework

Four recovery tasks have been identified: developing a positive identity, framing the 'mental illness', self-managing the mental illness and developing valued social roles. These recovery tasks and the central importance of relationships inform a framework for personal recovery.

The framework is consistent with the four key domains of personal recovery outlined in Box 9.2. Hope arises when the possibility of a more positive identity is felt. Identity involves reclaiming a sense of personhood outside of being a person with a mental illness, by developing a positive personal identity and valued social roles. Meaning involves framing the mental illness – finding a way of making sense of it (direct meaning) and its implications for the person (indirect meaning). Personal responsibility involves the development of the ability to self-manage the mental illness and other life challenges.

These processes are based on the insights derived from stage models that there are characteristic transitions experienced by people in recovery. The four tasks of recovery are thus loosely ordered, to suggest a general but not universal ordering from belief to action and from personal to social.

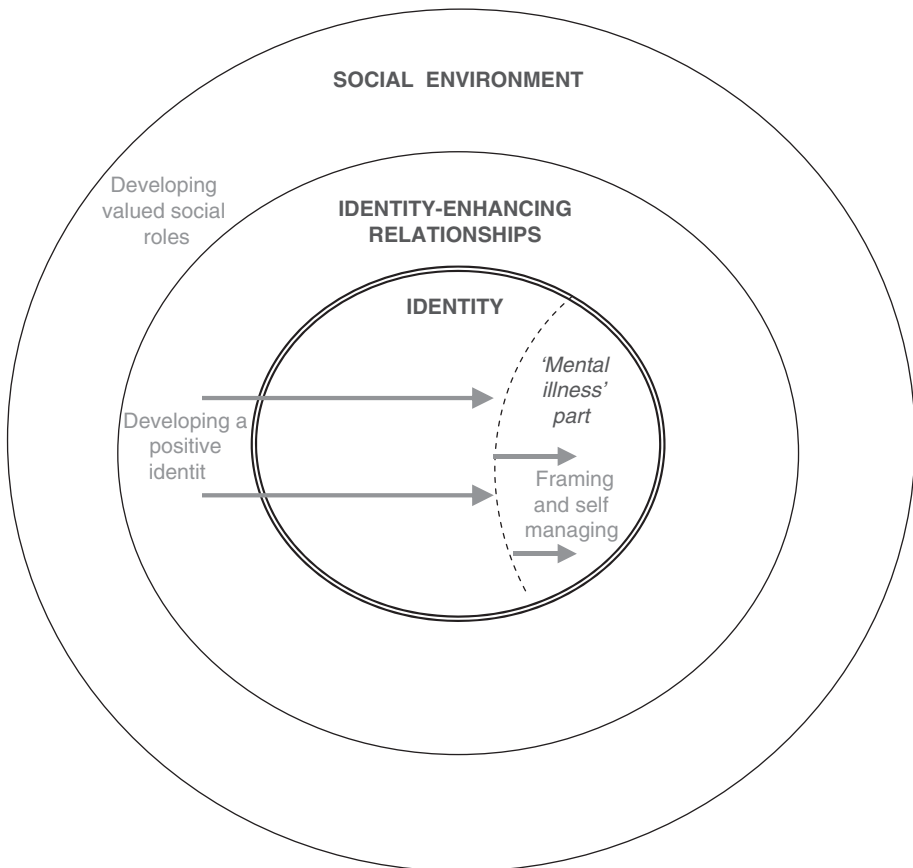This Personal Recovery Framework is summarised in Figure 9.1.

Figure 9.1 The Personal Recovery Framework.

The social environment comprises the world and others in it. Identity-enhancing relationships can be with the self, the mental illness or with the social environment. Figuratively, the process of recovery involves reclaiming a positive identity in two ways (shown as arrows in Figure 9.1): by identity-enhancing relationships and promotion of well-being which push the mental illness into being a smaller component of identity, and by framing and self-managing which pull the mental illness part. These processes take place in a social context which provides scaffolding for the development of an identity as a person in recovery.

Consistency with other frameworks

This framework is consistent with other approaches. For example, in seeking to implement a recovery strategy in New Zealand, the Mental Health Commission published a recovery framework based on the narratives of 40 people who have recovered from mental illness[107]. Their framework has the acronym RECOVER, and is shown in Box 9.4.

The RECOVER framework is consistent with the Personal Recovery Framework – it emphasises self-management, growth through the sustained development of a positive personal and social identity, and the importance of supportive relationships.

An alternative framework is provided by David Whitwell, who identifies seven naturalistic factors which impact on recovery: Time; Relationships; Life events; Employment; Shock (something which jolts the person out of the mindset of identity as a person with a mental illness); Development of new interests; and Access to money and housing[22]. This is

---

Box 9.4 The RECOVER framework

Reading, researching and learning from others about mental health

Learning to recognise the signs of ill health

Emotional growth

Change of circumstances

Change of residence, Making a new commitment to employment or further education, New family responsibilities

Others: experiencing social support

Family/Whānau assisting recovery, Faith, Active support, Challenge in the context of support, Partners, Friends, Mental health workers, Health providers as counsellors, Quality of relationship, Health providers as teachers, Health providers creating an appropriate cultural setting, Support groups, Miscellaneous supportive others (boss, work colleague, pet)

Virtues – practising them

Good general health practices, Avoiding known triggers and stressors, Recognising warning signs of impending mental health problems and taking preventive action, Using medication thoughtfully, Emotional release, Psychological/cognitive techniques to overcome thoughts and behaviour symptomatic of ill health, Spiritual practices, Pushing at limitations

Etcetera

Individual strategies, e.g. money

Repeat strategies that work and realise that recovery takes time

compatible with the Personal Recovery Framework. It emphasises that recovery happens in stages, arises from an interplay between the person and their environment, and that relationships and the ability to access normal social resources are crucial.

What does the Personal Recovery Framework imply for the job of mental health professionals?

The job of mental health professionals

A personal recovery-focussed mental health service would be organised to support individuals to undertake the four recovery tasks, and underpinned by an emphasis on relationships. Since personal recovery is something the individual experiences, the job of the mental health professional is to support the person in their journey towards recovery. Drawing on the synthesis of the four key domains of recovery shown in Table 9.1, four groups of support task can be identified.

The task of supporting hope

Mental health professionals can support the development of hope by fostering relationships. We explore this in Chapters 10 to 13. Additionally, because hope dies without opportunity,
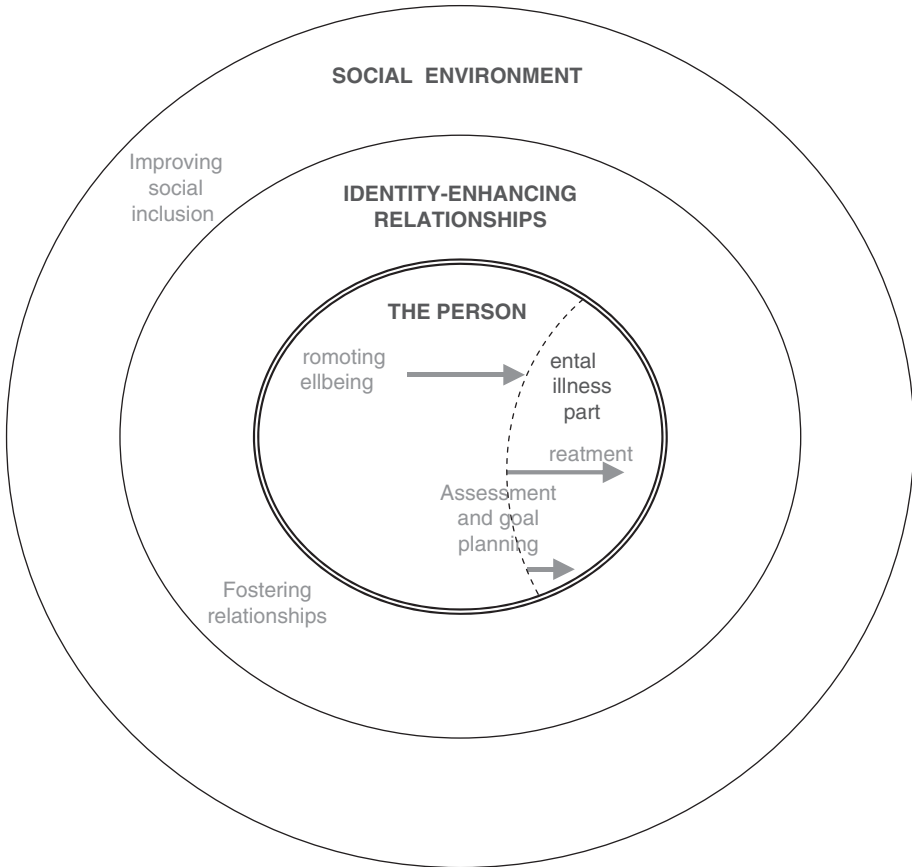

Figure 9.2 The recovery support tasks of mental health professionals.

an important job of a recovery-focussed mental health professional is to improve social inclusion, as discussed in Chapter 23.

The task of supporting identity

Mental health professionals can support the development of a positive identity by promoting well-being (discussed in Chapter 14) and goal-planning (Chapter 17) which encourages personal growth and development.

The task of supporting meaning

Mental health professionals can use the assessment process to support the person to find their own meaning in their experiences, discussed in Chapter 16.

The task of supporting personal responsibility

Treatment matters, and offering evidence-based interventions which foster self-management is often a vital contribution to recovery, as discussed in Chapter 18.

In Figure 9.2 these support tasks are positioned in the Personal Recovery Framework.

We begin at the beginning, with relationships. In Chapter 10 we consider relationships with a higher being, and in Chapter 11 close relationships with others. Chapter 12 identifies the central importance of relationship with other people who have experienced mental illness. In Chapter 13 we consider the relationship between the mental health professional and the consumer.

Fostering relationships with a higher being

What truly heals? This chapter unpicks some aspects of healing.

Healing

People need to recover not only from the mental illness itself, but from its emotional, physical, intellectual, social and, most importantly for some, spiritual consequences. Healing may not be supported by mental health services until they attend to these broader and deeper impacts[333]:

> The healing process not only incorporates a new way of living with and controlling symptoms, but also an increasing adeptness of navigating social realms to overcome stigmatizing and discriminatory social-structural beliefs and practices. Re-authoring hinges on reclaiming a positive self-concept.
>
> (p. 14)

Healing is a complex activity, which can be understood in spiritual terms[345]:

> Spirituality is an extraordinary part of the ordinary lives of people. From birth to death, spirituality is manifest in life's turning points, revealing mystery and depth during these pivotal moments in time . . . In crisis and catastrophe, spirituality is often intertwined in the struggle to comprehend the seemingly incomprehensible and to manage the seemingly unmanageable.
>
> (p. 3)

Many clinicians find spirituality problematic. When supervising cognitive-behavioural work with clients whose delusional content is religious, I have observed that the therapist often experiences a conflict of values. On the one hand, the standard cognitive therapy approach to delusions involves empirical reality testing. On the other, the social value of not directly challenging another's religious beliefs is difficult to violate, and the expectation that religious beliefs should accord with the same standards of proof we would expect of other unusual beliefs (e.g. that the neighbours are plotting against us) feels wrong.

More generally, clinical staff often feel under-skilled in relation to spirituality, anxious about causing offence, and uncertain of the link between the clinical and the spiritual. Perhaps this is a legacy of Freudian views of religion as regressive and pathological. Perhaps it is because professionals have (statistically) abnormal spiritual views – 90% of the US population believe in a personal God, compared with 24% of clinical or counselling psychologists[345]. Whatever the reason, the resulting behaviour does not foster spiritual development. Sometimes people are even discouraged from spiritual exploration, in case it exacerbates religiose delusions. More commonly, terms such as healing, God and soul are rarely uttered by clinicians, let alone discussed or supported as a primary focus of work. This silence sends a powerful message about what matters, which actively impedes the

journey of many people towards recovery. The reality is that many people in recovery identify that having some form of faith is an important source of love, support and a sense of belonging when they feel abandoned by others[107;346].

Spirituality

How could this change? First, some conceptual clarity. In relation to mental health services, it is helpful to separate spirituality from religion. Pargament defines religion as a broad individual and institutional domain that serves a variety of purposes, secular as well as sacred, whereas spirituality represents the unique function of religion[347]. Spirituality can then be defined as *a search for the sacred*. The *search* can involve: traditional religious institutions (e.g. church, mosque, temple) or non-traditional organisations (e.g. Twelve Steps, meditation centres); belief systems from early organised religions (e.g. Jewish, Buddhist, Christian) or from newer spiritual movements (e.g. feminist, goddess, ecological spiritualities); and conventional religious practices (e.g. scripture reading, prayer, rites of passage) or other human expressions that have as their goal the search for the sacred (e.g. yoga, art, music, social action).

Sacred has been defined as including[348]:

> concepts of God, the divine, and the transcendent. However, other objects can become sacred or take on extraordinary power by virtue of their association with, or representation of, divinity[347]. Sacred objects include time and space (the Sabbath, churches); events and transitions (birth, death); materials (wine, crucifix); cultural products (music, literature); people (saints, cult leaders); psychological attributes (self, meaning); social attributes (compassion, community); and roles (marriage, parenting, work).
>
> (p. 647)

Separating religion from spirituality makes discussion of spirituality more possible in a mental health context. A search for the sacred, or trying to find a connection with a higher meaning or purpose in life, is a unifying human endeavour. Religion, whatever else one may say about it, does not unify humanity. In a conversation about spirituality, the focus is not on what religious group the clinician does or might belong to. Rather, the topic is how the consumer can develop as a spiritual being. There is less concern about an implicit agenda of conversion. The personal beliefs of the clinician then become less relevant, which paradoxically liberates the clinician (if consistent with their therapeutic orientation) to refer to their own spiritual experiences where helpful.

A second rationale for focussing on spirituality is that it makes visible commonalities across different traditions. For example, spiritual methods of coping with adversity include marking boundaries, spiritual purification and spiritual reframing[349]. Averill suggests that important elements of spiritual experience can be understood in either secular or spiritual terms[350], shown in Table 10.1.

The need to feel alive, to have uplifting experiences and to be part of something larger than oneself is central to the recovery narratives of many people. The consistent theme is a recognition that we cannot always help ourselves by personal effort, and that connection with a higher being is enriching.

Mental health services can support spiritual development

How can the person be supported by mental health professionals in their spiritual development? A straightforward strategy is simply to ask the person about meaning and purpose in

Table 10.1 Elements of a spiritual experience

	Description	Secular perspective	Spiritual perspective
Vitality	A powerful force, a creative attitude, being 'free-spirited', adventurous, open to new experiences, or growing through inner exploration or meditation	Health Energy Enthusiasm	Soul Grace Sanctity
Meaningfulness	Spiritual experiences are deeply felt, sometimes life-changing. Meaning may take time to emerge. This can be associated with a sense of mystery and awe	Art Science Literature	Faith Scriptures Revelation
Connectedness	A feeling of union or harmony with another being or thing. This may involve connection with a living, dead or imagined person, a cultural or ethnic group, humanity or nature. The common theme is self-transcendence – an identification with something beyond the self.	Family Lovers Nature	God Fellowship Church

their life. This will be stepping outside the clinician's sphere of expertise, but may also be stepping into the patient's sphere of need. What has the experience of mental illness taught the person? How has the person's sense of what life is about changed over time? When does the person feel most alive, or most connected with something or someone else?

Whitwell notes that spirituality – inner life, meaning and purpose, the 'ground' in which the person is the figure – can all be demolished (either temporarily or permanently) by the experience of profound mental distress[22]. The path to recovery can then involve reconnecting with previous sources of comfort and sustenance, which is a much more active and transformative process than going back to how you were. Or it can involve developing new sources of support, new meanings in life, and even new realisations about the self which lead to the positive aspects of mental illness described in Chapter 2. The task of the mental health professional is to set a context in which these powerful processes can happen.

Resources to help clinicians to support spiritual development are becoming available (e.g. www.spiritualcrisisnetwork.org.uk, www.spiritualcompetency.com). Although spiritual development is not easily amenable to action planning, mental health professionals can encourage this process by supporting the person:

- to nurture a positive view of the self, by demonstrating compassion in how the professional responds to the consumer when they report difficulties and setbacks
- to have spiritual experiences, such as reading scripture, prayer, attending places of worship, accessing on-line religious resources
- to have uplifting secular experiences, through exposure to art, literature, poetry, dance, music, science, nature
- to access opportunities for self-discovery, such as through personal therapy, keeping a diary, writing a poem or a song, developing a narrative about oneself
- to give back to others, e.g. voluntary work, having a pet, having responsibility for something or someone
- to develop a different relationship with their thoughts, e.g. by learning how to meditate, or through CBT
- to develop social capital, e.g. by experiencing citizenship, becoming politically active (including as a consumer activist)
- to develop cultural identity, e.g. by accessing culture-specific groups and through healing and purifying cultural ceremonies

- to access self-help and mutual support groups
- to undertake recovery planning activities, such as the Personal Recovery Plan developed by Ron Coleman[116], or the Wellness Recovery Action Planning developed by Mary Ellen Copeland[351]
- to have time to think, including a quiet place to go, and prompts which aid contemplation
- to take action: engaging in life rather than disengaging from life; making connections with the world, and other human and non-human beings in it; acting on the basis of approach rather than avoidance motivations.

This involves working in a very different way. Our first case study illustrates one approach to supporting this experience of connection.

Case study 1: Peace Ranch

Peace Ranch is set in 25 acres of countryside in Caledon Hills, north of Toronto. It was established in 1990, and provides opportunities for people with mental illness to experience agriculture, animal husbandry and country life. It is a working farm, with goats, sheep, hens, peacocks, cats, donkeys, horses and a frighteningly large pot-bellied pig. Staff have a range of training, including therapeutic riding, horticultural therapy, social recreation and farming. The emphasis is on supporting individuals: 'through doing things for themselves, our residents learn the value of managing their own lives'. Ten residents live in the farmhouse, and 100 people attend the day programme.

Residents start the day with barn chores: feeding and cleaning for animals. Moving into a role where you are caring for someone 'moves the person to being a champion' – it encourages empathy and caring for others. The sense of responsibility and accomplishment is something worth getting up for. Daytime activities include therapeutic garden design, animal care, horseback riding, apple cider pressing, farmhouse cooking, hiking, maple syrup production and country crafts (e.g. pumpkin-carving). Many activities are community-focussed. Produce is grown both for sale at markets and for entering into local competitions. Peace Ranch-on-wheels involves visiting seniors in their home and supporting them to plant, maintain and use herbs and other produce. Preparing the baby animals to appear in a petting zoo involves spending time holding and caring for them, because loved animals give love back. Going on to work in the petting zoo at local events gives an experience of mastery when children ask about the animals, and is a way of being a contributing member of the community.

Even a brief exposure can be transformative. The 'day in the country' programme offers a 'penetrative, rejuvenating silence' away from the pace of life in cities. The experience at Peace Ranch is all about discovering things outside yourself: conversation is focussed on the person's farm jobs and on nature rather than on illness. One resident identified the benefit that plants and animals don't judge: caring for them is 'one way you don't have to rely on other's perceptions'. This experience of authentic connection to nature, growth and food is new for many attenders. For example, gardening requires a focus on here-and-now activity. This grounding experience of living in the moment fosters peace of mind and a sense of being connected to the cycles of life. Growing something from a seed, nurturing the seedling and feeling pride at the result can invoke a sense of awe: something magical is happening. The doubt about whether the seed will make it is also a metaphor for the need for hope in life.

The economic impact of Peace Ranch is positive – after accounting for operating costs, over US$500 000 is saved per year through reduced hospitalisation rates. The personal impact is also clear, with some people experiencing their time in the programme as a punctuation point

Case study 1: (*cont.*)

in their life. One ex-resident described coming for a day's taster, then a 6-month trial, followed by two years living on the farm. He reported that working with animals relaxed him – his mind stayed calm because he felt a bond with the animals. Sitting out at night under the stars in a non-light-polluted setting was also experienced as a powerful process – 'it touches the soul'. The routine of farm life provided him with a basis to address drug issues, and the consequent stability allowed him to move into independent accommodation. He is now working in the market gardening and petting zoo projects.

  Further information: www.peaceranch.com

The overall challenge is to develop an orientation towards fostering spiritual development. Emerging approaches such as supported spirituality[352] are one contribution, which seek to harness its healing potential. This encompasses many aspects: sustaining through difficult times in life; providing a way of making sense of the struggle for meaning, providing coping mechanisms; a means of accessing natural social support; a context for wellness and rules of behaviour (GOD as Good Orderly Direction in life); a valuing of acceptance of the need for help and of dependence; and a means of finding absolution for feelings of guilt and shame. Some relevant resources are available at ssw.asu.edu/portal/research/spirituality.

Spiritual development has the potential to generate hope. As we will discuss in Chapter 21, any crisis (e.g. a mental health crisis) requires a resilient response if the person is to move from succumbing to surviving and even thriving. In the language of positive psychology (described in Chapter 14), flourishing is possible even in the midst of adversity. What gets in the way is pessimism, negative thinking, wishful thinking, self-blame, unhelpful avoidance – things that sap a person's ability to engage with, and ultimately grow from, the crisis. The antidote to these negative influences is hope. The development of hope reconnects the person with their innate, self-righting capacity, and can be a deeply spiritual experience.

We turn now to more proximal relationships, with close friends and family in the person's social world.

11

Fostering close relationships

Close relationships are the important relationships between the person with mental illness and others (e.g. family, friends, neighbours, pets) with whom they are in meaningful contact. People with mental illness often have reduced social networks[4], so remaining relationships are vital. If the primary goal of mental health professionals in fostering close relationships is to support the person's recovery, then what does this mean in practice?

To illustrate, consider a mother who expresses concern to a clinician about her son John, a voice-hearer, who is sleeping late in bed every day, and regularly smoking cannabis. One response would be:

> I can see why you're concerned. We know that people who isolate themselves are more vulnerable to an increase in auditory hallucinations, losing motivation and becoming depressed. There is also good evidence that cannabis makes a psychotic relapse more likely. So you need to find some way to get him into a normal pattern of getting up, but without criticising him or treating him like a child. He has to make his own choices, you see – otherwise if you take over he's again more likely to relapse. I'll also encourage him to get out of bed earlier the next time I see him.

The explicit communication is empirically supported – self-monitoring deficits are increased in the absence of external stimuli[353], cannabis is associated with increased likelihood of relapse[354], and emotional over-involvement and critical comments do contribute to increased relapse rates[355]. However, the implicit communication has a number of anti-recovery components:

1. The clinician is the expert, shown by discourse markers ('We [i.e. I] know that . . .', 'There is also good evidence that . . .') and use of jargon
2. The assumed job of the clinician is to provide advice to fix the problem
3. The advice is focussed on avoiding bad things happening to John, such as symptoms or relapse
4. The focus on symptoms and difficulties communicates that positive change is unlikely
5. The advice puts the mother in a double bind – damned if she does try to badger John out of his bed, damned if she doesn't
6. Improvement in John will happen on the basis of action by the clinician or by John's mother.

Consider this alternative response:

> I can see why you're concerned. John is isolating himself, which means his voices may get worse, and it's also hard for him to get much enjoyment, so there's a risk his mood will drop. And you'll know that cannabis can make John's voices get worse. So we need to understand what stops John from being a bit more active. Now, you know him better than I do. What good things does John have to get up for? . . . If there's nothing,

> then I have a check-list of things some people find enjoyable. Can you ask him to fill it in – do go through it with him if he wants – and then try to discuss with John how to develop some opportunities? Could you also ask him to bring it along the next time he sees me, as I'd be interested to see what he puts?

The explicit communication is the same. However, the implicit communication has a number of more helpful contributions to promoting personal recovery:

1. The clinician has relevant expertise, but does not position themselves as the expert – shown by discourse markers ('you know him better than I do'), expectations of knowledge being shared rather than exclusive ('You'll know that . . .'), and lack of jargon
2. The job of the clinician is to work with the mother to support John in developing his own solution
3. The clinician's response is focussed on increasing the chance of good things happening to John, such as finding something he enjoys
4. The response is positive but realistic – change is actively expected, but the concerns are real and the goal is to be 'a bit more active'
5. The mother has a concrete task to do, but one which is collaborative rather than prescriptive. The concern about Expressed Emotion therefore doesn't need to be voiced.
6. John has the answers, although he may need very active support from his mother and the clinician to find a way forward.

Of course, it is possible that John simply wants an alternative lifestyle. For example, I supervised work with a service user who wanted to be a musician, and whose ideal day was rising mid-afternoon, playing a gig in a local pub then jamming with friends until going to bed at sunrise. This person did not lack motivation for his own goals, but he did for the service goal of a normal sleep pattern. Returning to John, it would probably be unhelpful to invalidate the mother's concerns by exploring this issue with her. In individual work with John, the clinician may explore his lifestyle choices. What kind of person does he want to be? Who does he aspire to be like? What would his ideal day look like? If it emerged that John wanted a more nocturnal life, then of course that should be accepted, valued and supported.

The general principle is that close relationships are vital: they shape identity, and contribute to or hinder well-being. Supporting close relationships can be a powerful means of promoting hope. The clinical challenge is to balance this goal with the recognition that not all close relationships are beneficial. This involves the normal clinical skill of balancing inter-dependence on others with the promotion of personal autonomy. Frameworks are now becoming available to inform decision-making in this area[356], which highlight that clinical judgement remains centrally important. Ceding power to the consumer does not remove the expectations on clinicians to apply their professional expertise and wisdom in their work. Many clinical dilemmas are complex, with no simple, or even right, solution[198]. The challenge is to develop a values base such that the clinical bias is towards actions that promote, rather than hinder, personal recovery.

One approach to harnessing the recovery-promoting potential of family members is to involve carers in mental health services. This approach is used in the next case study.

What about intimate relationships, such as marriage and lesbian, gay and straight partnerships? International comparisons highlight marked differences in relationship rates. A recent authoritative study found that nearly three-quarters of Indian people with a diagnosis of schizophrenia were married at follow-up, compared with about one-third from the developed world[114]. So the likelihood of an intimate relationship is influenced by cultural factors.

Case study 2: family peer support workers

The ORYGEN Youth Health service employs trained family peer support workers, who are parents of people who have previously developed mental health issues. Their role is to act as 'carer consultants', providing a service to other parents and family of people referred to ORYGEN. Family peer workers actively seek to engage with families, including phone and face-to-face contact, through liaison with other ORYGEN services, particularly out-patient case-managers and through visiting the in-patient unit. They have also set up a family resource room which families can access when they bring their young person along to the main ORYGEN site.

A key feature is that their role is to be a paid non-professional with lived experience, whilst they actively work alongside the mental health clinicians at ORYGEN. A central value is to integrate this programme with the clinical services, not to create parallel systems. Some case managers initially expressed concern about working at cross-purposes with the family peer workers, for example in relation to what advice they would offer. This has been addressed by providing the family peer support workers with regular supervision from an experienced clinician and having clear guidelines about the role of family peer support workers. Case managers are also invited to family peer supervision meetings, where they can discuss referrals and management plans. Information that will assist family peer support workers with supporting the family is helpful. Some of the family peer support worker duties include:
- acting as a positive link between the service and the carer
- understanding and giving *emotional* support as another family member who has been through a similar situation
- encouraging the family member to feel empowered and to discuss specific questions with the case manager, and offering to be a go-between where helpful.

Further information: info@orygen.org.au

The challenge for mental health professionals is then to avoid communicating impoverished expectations to patients about the possibility of their experiencing a rich and fulfilling intimate relationship. It goes without saying that any discussion about this should take account of the individual's sexuality, so staff need to demonstrate sensitivity to the different patterns and compositions of intimate relationships. However, the deeper problem is one of silence – sexuality and intimate relationships are routinely not discussed with patients, other than when screening for problems during the Sexual History element of a Mental State Examination. For example, the Camberwell Assessment of Need is a standardised assessment of 22 domains of health and social needs for people with severe mental illness[357], and Sexual Expression is the domain most frequently rated as 'Not known' by staff[358]. This is worrying not only because of the clinical importance of asking about a domain of life commonly impacted on by side-effects of neuroleptic medication, but also because it may reflect unstated staff beliefs that a fulfilling sex life is not available to people with mental illness.

This absence of enquiry may also be linked to the treatment-focussed training of professionals – a belief that if they identify an unmet need then it's their job to do something about it, and what can they do in this domain? One aspect of personal recovery that is liberating for staff is that responsibility for improving the person's situation shifts from them to the consumer. It becomes more possible to have open discussions about a life challenge, without the clinician feeling obliged to fix it. This links with the discussion in Chapter 5 about acknowledging 'I know not' in the face of complex life difficulties, rather than adopting an expert 'Do what I say and all will be well' stance.

The roles of coach or mentor are more helpful (and enjoyable) for staff in relation to complex social issues such as an unfulfilled sex life, because they open up new possibilities of action. In Chapter 23 we will show that the best employment approach is to experience real-life work, rather than training the person until they are ready for work. Similarly (though without the empirical evidence base), the best response to someone who wants an intimate relationship might involve supporting them to do things which give access to a pool of potential partners, such as joining a social or sports club, doing voluntary work, using an internet dating service, or going on a speed dating event. These proactive approaches are stretching, in different ways, for the individual and the clinician. The individual may need support to take on these challenges, and it may be more helpful to frame them as learning opportunities rather than expecting initial success. Ongoing involvement and debriefing may well be required as the person learns to cope with the ups-and-downs these experiences will involve. Similarly, the clinician may need support through supervision to move beyond constraining clinical beliefs, such as the importance of being better before doing normal things like dating. Of course, some of these actions will be premature for people in the early stages of recovery, but the principle is to ensure that impoverished expectations and stigmatising beliefs do not preclude normal, mainstream ways of addressing common (in both senses) human problems.

We now turn to the relationship between people with mental illness and others who may be further along their road to recovery from mental illness.

Peer relationships

There is a growing recognition that peers – people with their own experience of mental illness – can directly contribute to the recovery of others[300;359;360]. Meaningful peer involvement is universally associated with innovative recovery-focussed services internationally.

A recommendation for engendering hope is cited by Kirkpatrick and colleagues[361]: 'My suggestion is to get as many success stories as possible from those who have schizophrenia to give a sense of hope to those just beginning their journey'. How can this be done? Three levels of peer support for recovery can be differentiated: mutual self-help groups, peer support specialists and consumer-operated services.

Mutual self-help groups

Mental health systems traditionally give primacy to expert knowledge gained through professional training and education. A direct consequence, from the service user's perspective, can be that the mental health system is structured to give professionals control over the service and people using the service[362]. As a consequence, self-help or mutual support groups have in general developed outside mental health services. They give primacy to lived experience, leading to structures based on the assumption that all participants have something to contribute. Organisational structures tend to be more egalitarian and less hierarchical, with a wide range of role and participation opportunities[363]. They also promote political and social activity[333]: 'Connections among peers allow a nonpathologizing community discourse that is less susceptible to judgment and fosters expressions of power and collective social action ... These actions serve to counteract the stigma imposed by society and internalized by individuals while instilling meaning in life pursuits' (p. 16).

Mutual self-help groups vary in their level of connection with traditional mental health service values and beliefs. For example, the Hearing Voices Network (www.hearing-voices.org) runs groups which offer a safe haven in which voice-hearing people can feel secure and comfortable whilst working towards regaining some power over their lives. It emerged from the work of Marius Romme[42], and emphasises accepting and living with voices. Schizophrenics Anonymous (www.sanonymous.org), by contrast, is a self-help organisation for people with a diagnosis of schizophrenia which aligns with a biomedical model of mental disorder[195], yet the guiding principles of Schizophrenics Anonymous are clearly pro-personal recovery:

1. I surrender ... I admit I need help; I can't do it alone

2. I choose ... I choose to be well. I take full responsibility for my choices and realise that the choices I make directly influence the quality of my days

3. I believe ... I now come to believe that I have great inner resources and I will try to use these resources to help myself and others

4. I forgive . . . I forgive myself for all the mistakes I have made. I also forgive and release everyone who has injured or harmed me in any way

5. I understand . . . I now realise that erroneous, self-defeating thinking contributes to my problems, unhappiness, failures and fears. I am ready to have my belief system altered so my life can be transformed

6. I decide . . . I make a decision to turn my life over to the care of God, as I understand Him, surrendering my will and false beliefs. I ask to be changed in depth.

Katie Randall and Deborah Salem identify four key elements of mutual self-help groups[195]:

1. *Personal stories and community narratives*

   Personal stories are told, often repeatedly, within settings which shape self-understanding and identity. These normative narrative communities[364] promote recovery by helping participants make sense of their experiences in less stigmatising ways. Telling one's story is cathartic, promotes reflection, is reciprocal, and for some people may only be possible peer-to-peer.

2. *Role models*

   Leaders within the self-help group are visible role models. Hearing the experiences of others struggling with similar issues is normalising (i.e. the opposite of stigmatising), and can be inspiring and promote hope.

3. *Opportunity role structures*

   The core belief about all participants having value and something to offer translates into an assumption that all members can both give and receive help.

4. *Social support, sense of belonging, and connection*

   Self-help groups stress both the importance of taking personal responsibility and the need for support. Consequently they emphasise social support, belonging, connection and community.

Supporting access to an external mutual self-help group can be an important recovery support by a clinician for an individual consumer. However, the external positioning of mutual self-help groups reduces their direct impact on the mental health system. Since it can be challenging for clinicians to work in a recovery-focussed way – their instinctive responses are conditioned more by professional socialisation toward clinical rather than personal recovery – involving consumers as employees in the mental health system can have a transformative effect.

Peer support specialists

Terms such as peer support specialist[360], peer worker[365], consumer employee[366] and prosumer (professional consumer)[367] all describe roles in the mental health system for which personal experience of mental illness is required. The term peer support specialist (or simply peer) will be used here to describe this role.

Creating peer support specialist roles brings four types of benefit.

1. For the peer support specialist, it is a job with all the benefits that follow from this. Their own lived experience is valued, which can be a transformative reframing of an illness experience. They give to others, which is an important component of healing. Self-management and work-related skills are consolidated.

2. For other staff, their presence leads to increased awareness of personal values. Since very few mental health workers disclose a history of mental illness to their co-workers, there

is no challenge to the them-and-us beliefs about fundamental otherness held by many mental health professionals[70]. Interacting with peer colleagues challenges these beliefs in a natural rather than forced way. It is a common experience of staff to initially feel they can't talk freely when a peer joins the team, but over time this raised self-awareness becomes a means of identifying and addressing unhelpful values and beliefs.

3. For other consumers, exposure to peer support specialists provides visible role models of recovery – a powerful creator of hope. This type of benefit is increasingly being recognised in other areas of medicine, such as the importance of patient contact with survivors of cancer (www.acscsn.org, www.cancercenter.com). There may also be less social distance than with professionals, leading to more willingness to engage with services. For example, clients of an assertive outreach team who were allocated to receive input from a peer support specialist in addition to standard case management had greater levels of engagement and fewer needs[366]. Peers tend to focus on practical support needs, which can be vital. They are less constrained by social constructions of a professional relationship, so can offer friendship.

4. For the mental health system, peer support specialists can be carriers of culture. There is often less need to train and maintain a pro-recovery orientation in recovered consumers, because of their own lived experience. They promote these values in their interactions with other workers and with the system as a whole.

The peer support specialist role has policy support in many countries. For example, in England[301]: 'All mental health services will be expected to recruit and train service users as part of the workforce' (p. 21).

What skills are needed to work as a peer? Just as professionals need training, there is a need to train individuals who have experienced mental illness for working as a peer support specialist. The Intentional Peer Support approach of Shery Mead[360] identifies four cornerstones/tasks: Connection (engaging with others), Worldview (self-awareness about their own values), Mutuality and mutual responsibility (relationships in which both people have value and reciprocity is possible) and Moving Towards (harnessing approach motivation). In the USA there are now established training programmes, e.g. in Georgia[368], Arizona (see Case study 24) and Boston (see Case study 17). In other countries the infrastructure is developing, e.g. Scotland (see Case study 4). Even where no established training programme exists, it is still possible to prepare individuals for aspects of the role. For example, a necessary skill for working as a peer is the ability to tell one's own story. Many consumers are unaware that they have a story to tell which could be of benefit to themselves and others. The next case study is an initiative in Philadelphia which aims to develop this skill.

Case study 3: Sharing Your Recovery Story

The *Sharing Your Recovery Story* training helps people in recovery from mental illness to discover their story in a new way and begin to develop a simple structure for their story. The training focuses on helping people identify the 'recovery' portion of their story: what they did to get from the hard time to the place they are in now.

The training uses techniques drawn from the storytelling world of story listening and appreciations as a way to help people begin to develop their story in new ways. It is based on the belief that we are all born storytellers; we just lose touch with our story along the way. People express appreciation at the end of the training, and often make new peer-to-peer connections, providing extra avenues of support.

Case study 3: (*cont.*)

The training has been delivered in Philadelphia and surrounding counties, and has served as an entry point for people in recovery to connect to the system in new roles. People have moved on from this training to participate as trainers in other trainings, to share their story in public venues designed to increase awareness of recovery transformation and to decrease stigma, to become certified peer specialists and to assume other leadership roles within the mental health system.

The original storytelling training has been supplemented with several additional approaches:

- Family member storytelling training: focusses on the family experience when a loved one has a mental illness. Training has included parents of young and adult children, siblings, spouses and extended family members. Again, reviews have been overwhelmingly positive and this training is providing impetus to the family inclusion initiative in Philadelphia.
- Youth Storytelling Training: for adolescents who have received services in the system.
- Storytelling Training for staff: while staff are invited to participate in the original storytelling training this was developed to provide staff with additional skills to run storytelling groups at the programmes in which they work.

Further information: Joan Kenerson King (jking@netreach.net)

Many challenges arise from creating peer support specialist posts, and are worth considering in advance. A clear and distinct job description for the peer support specialist is important, or the role is vulnerable to being co-opted. It is tempting for service managers and administrators to consider reducing staffing costs by replacing expensive professionals with cheaper staff, but using peer support specialists to achieve a cheaper workforce doing the same tasks will neutralise their contribution.

Two concerns that are sometimes expressed relate to confidentiality and safety. The confidentiality concern is that peer specialists will have access to confidential clinical records. However, the same rules of confidentiality govern peer support specialists as any other type of employee. Employees breaching confidentiality policies should face disciplinary action. The safety concern is that some peer specialists may be damaging to those with whom they work. Whilst there certainly are people with experience of mental illness who should not work as peers, this risk is exaggerated due to stigmatising beliefs linking mental illness and violence (as we discuss in Chapter 20). The actual level of risk should be dealt with as per any other applicant – there should be a formal recruitment and selection process, and policies in place to deal with unacceptable behaviour.

Since not everyone with their own experience of mental illness will make a good peer, several issues should be explored during the recruitment process. Does the person show humility about their own experience, or will they attempt to impose their solution on others? Can the person talk about their own experiences, as a source of suffering from which they can draw, but with sufficient distance that they can use their experiences as a resource for others? Does the person accept their own limitations, show good self-management skills and a readiness to seek support from others? Does the person show passion, enjoyment in their own life, a sense of playfulness – or other evidence that they have transcended a role defined by mental illness and connected with the stress-buffering effects of play and pleasure[330]?

Working as a peer is not always easy. Common issues include uncertainty from clinical services about their value, credential barriers for potential peers with no formal qualifications, cultural tensions where services do not engage well with specific peers, a lack of training

opportunities, lack of support to manage their own mental illness and meet the emotional and physical demands of paid work (especially if they are coming from unpaid, voluntary or no work), poor career development opportunities, the impact on welfare benefits, the lack of a living wage, and maintaining a (partial) identity as a consumer rather than a mini-professional. This last challenge arises because many peers report feeling an impostor – neither a proper consumer nor a qualified professional. Balancing these role tensions is not easy. A qualitative study of the experience of five peers identified six types of role strain[369]:

1. Super cool – they could not express a normal range of emotions in their work-place, e.g. anger, elation, being 'down in the dumps'
2. Super normal – they felt they needed to be conservative in appearance and behaviour
3. Super person – they felt they were expected to be experts in every area of mental health
4. Unskilled – they felt they were seen as unskilled, with colleagues assuming they had no other education and skills than what was inherent in being a consumer
5. Voyeurism – staff wanted to know details of illness and admission experiences without wanting to hear the lessons that could be learnt from them
6. Remuneration – the absence of pay scales created problems in getting a wage that reflected the work they did.

   Participants identified approaches to dealing with these strains:

- Consumer humour (used with other consumers, parodying their consumer background and the 'normality' of non-consumer colleagues)
- Debriefing with other consumer colleagues, being open without the fear of being pathologised
- A thick skin to deal with the everyday ignorance and discrimination they experienced
- Perspective about the big picture – reminding themselves that they are there to change the culture, and having reminders (e.g. sitting in a ward)
- Supervision to deal with the stresses of employment.

Key organisational approaches to supporting the role were identified as policies and procedures, positive senior management support, a liaison person, a clear job description and expectations, having more than one peer in post, flexible working hours and acceptance that disability may require time off work. Good supervision, as for any other mental health worker, is vital. Challenging prejudicial beliefs about ability is also important. For example, a study in Connecticut showed that former consumers are as able to work as case managers as anyone else[370]. Our next case study describes how one country is developing a cohort of peer support specialists.

Case study 4: developing a peer support specialist infrastructure

International collaboration has underpinned Scotland's efforts to introduce peer workers as part of their mental health service system. In December 2005 a number of leading exponents of peer working from the USA were invited to speak at a conference organised by the Scottish Recovery Network (SRN), about the role and potential development of peer working in Scotland. Speakers included Larry Fricks, then of Georgia Certified Peer Specialist Project, and Gene Johnson and Lori Ashcraft from Arizona-based Meta Services (now known as Recovery Innovations).

This event generated huge interest in peer working in Scotland and eventually led to a Government commitment to support this new role where people with lived experience of mental health issues and recovery are trained and employed as specialist recovery workers.

Case study 4: (*cont.*)

The first peer support service in Scotland is called Plan2Change. Based in Edinburgh, it was developed initially as a partnership between NHS Lothian, Penumbra and the Scottish Recovery Network. This project was funded via Social Inclusion and aimed to work with people experiencing considerable life difficulties but not necessarily in receipt of secondary mental health services. Training for the peer workers, who link closely with local primary care and other service providers, was provided by Recovery Innovations in late 2006.

This intensive two-week course was then repeated in 2007, meaning that in total over 40 people had now been trained across Scotland as peer specialists. Some of these people have now gone on to take up roles as employed peer workers in a number of Health Board areas as part of an evaluated pilot project, linked to the Scottish Government's commitment, as described in Delivering for Mental Health[298].

Peer workers in these pilots are fulfilling roles within community and inpatient services. The majority are employed by NHS Boards but some are employed by a service-user-led organisation and placed within statutory services.

Further information: www.scottishrecovery.net

The development of peer support specialist roles also creates new ethical dilemmas. For example, there is professional consensus that it is never appropriate to have sex with a consumer. This invariant rule works well where there is a clear distinction between consumer and employee, but how does it apply when peers are employed in the workforce? Does becoming a peer support specialist mean that an existing sexual relationship with another consumer needs to be severed? What about where a new sexual relationship is likely to develop?

How do peer support specialists work? A key difference is in the way of relating to consumers: peers create partnership and real relationships rather than detached relationships – terms we elaborate in the next chapter. They exemplify the recovery coach – a term developed in the addictions field[371]:

The role of a recovery coach is a:

- *motivator and cheerleader (exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement)*
- *ally and confidant (genuinely cares, listens, and can be trusted with confidences)*
- *truth-teller (provides a consistent source of honest feedback regarding self-destructive patterns of thinking, feeling and acting)*
- *role model and mentor (offers his/her life as living proof of transformative power of recovery; provides stage-appropriate recovery education and advice)*
- *problem solver (identifies and helps resolve personal and environmental obstacles to recovery)*
- *resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social service, and recovery support)*
- *advocate (helps individuals and families navigate the service system, ensuring service access, service responsiveness and protection of rights)*
- *community organiser (helps develop and expand available recovery support resources)*
- *lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living) and*
- *a friend (provides companionship)*

This list provides an outline of how peer support specialists work. A key focus is on enhancing recovery capital – the internal and external assets required for successful recovery initiation and maintenance[372]. The basic orientation of a peer support specialist is towards amplifying and supplementing natural recovery supports, rather than replacing these assets. This is no different to what we will argue (in the next chapter) a partnership relationship between a clinician and a consumer needs to look like if it is to support recovery. However, the two advantages of peers is that they have a personal experience of recovery to draw on, and they have not in general experienced the socialisation of professional training which can encourage a doing-to (i.e. replacing natural supports) mentality.

This means that the instinctive responses of peers can be highly supportive of recovery. They offer a counterpoint to the tendency of mental health professionals to unwittingly avoid certain topics, such as the experience of being compulsorily detained or being forcibly medicated. Peers also easily recognise the value of having time off from the illness experience, through activities such as gardening, travel, socialising and film-watching. These kinds of activities promote the experience we will discuss in Chapter 14 of being in flow, with all the consequent benefits for a meaningful life. They easily value the meaning found in the experience of contributing or giving back: 'I'm part of the world, I'm a human being, and human beings usually kind of do things together to help each other out'[373] (p. 288). This experience can take many forms: sending birthday cards; looking after a pet; taking part in research; becoming a peer worker. The common theme is that giving back contributes to the move from being someone who 'didn't feel like I deserved to have a halfway decent life' to coming to 'not be afraid to take things from people in return'[330] (p. 156).

Peer support specialists do not have to be people with substantial life experience – the main criterion is that they are further along the recovery road. At the ORYGEN Youth Health service in Melbourne, past programmers (i.e. people who have been through the programme) are employed as peers.

Case study 5: youth peer support workers

The ORYGEN Youth Health service employs peer support workers. Peers are recruited by interview into voluntary posts, and provided with monthly supervision from experienced clinicians about issues arising in their work. Though the position is considered voluntary, the young people are reimbursed for their time and travel.

The peer worker role is developing. For example, peer workers visit (in pairs) the acute in-patient mental health unit twice a week. Their goals during the visits are:
- to engage residents on the unit in meaningful activities and conversation
- to provide peer support
- to provide information about the ORYGEN service
- to provide the opportunity to mix with other young people who are further down their pathway to recovery
- to address the stigma associated with attending the ORYGEN programmes, and encourage involvement in the group programme
- to provide advocacy, e.g. signposting to complaints procedures.

Peer support workers also run a 'drop-in' room for several hours a week at the outpatient clinic. The drop-in room provides an opportunity for young people to meet together informally in a supportive, youth-friendly environment and to find out information from peers about ORYGEN services and other services available.

The peer support programme is embedded in a larger consumer-participation programme called The Platform Team, whose roles include contributing to service development,

involvement in interviewing panels, representing young people on committees, and providing a consumer advocacy service, including receiving media training before appearing on TV to discuss youth mental health.

Further information: info@orygen.org.au

If the involvement of peer support specialists in mental health services brings so many benefits, then the natural extension is to consider peer-run services and programmes.

Peer-run programmes

A peer-run programme, or consumer-operated service provider, is more than simply an organisation staffed by peers[359]. It is a service whose purpose is to promote personal recovery through its values and operating practices. This is shown by the Fidelity Assessment Common Ingredients Tool (FACIT)[374], which is a 46-item fidelity scale whose components are shown in Box 12.1.

Box 12.1 Components of the FACIT Scale

1. Programme structure
   - Consumer-operated (board participation; consumer staff; hiring decisions; budget control; volunteer opportunities)
   - Participant responsiveness (planning input; satisfaction/grievance response)
   - Linkage to other supports (traditional mental health services; other consumer-operated service providers; other service agencies)
2. Environment
   - Accessibility (local proximity; access; hours; cost; reasonable accommodation)
   - Safety (lack of coerciveness; programme rules)
   - Informal setting (physical and social environment; sense of community)
   - Reasonable accommodation
3. Belief systems
   - Peer principle
   - Helper's principle
   - Empowerment (personal empowerment, personal accountability, group empowerment)
   - Choice
   - Recovery
   - Acceptance and respect for dignity
   - Spiritual growth
4. Peer support
   - Peer support
   - Telling our stories: artistic expression
   - Consciousness-raising
   - Crisis prevention
   - Peer mentoring and teaching
5. Education
   - Self-management/problem-solving strategies
   - Education
6. Advocacy
   - Self advocacy, peer advocacy

There is an empirical evidence base underpinning peer-run programmes[359]. Reviews of their effectiveness have been undertaken by research groups in the USA[375–377], New Zealand[293] and England[378;379]. The findings are consistently positive[380]:

> Overall, these studies suggested that self-help and peer support programs can promote empowerment and recovery[381;382] . . . preliminary evidence suggests that these programs decrease the need for acute mental health services and mental health hospitalizations[381;383;384]; increase social support, functioning, and activities[383;385;386]; decrease substance abuse[381;383]; and may benefit perceived quality of life[377;387].
>
> (p. 786)

A systematic review of six randomised controlled trials, seven comparative studies and 13 descriptive studies concluded[293]:

> Overall, research on consumer services reports very positive outcomes for clients. This review of effectiveness found some studies that reported high levels of satisfaction with services, general wellbeing and quality of life while others reported no significant differences . . . No studies reported evidence of harm to service users or that consumer services were less effective than the equivalent services offered within a traditional setting.
>
> (p. 4)

For example, an eight-site randomised controlled trial across the USA investigated the impact of participation in consumer-operated service programmes[380]. The study found that participants experienced increased empowerment in services which implemented the active ingredients, and that a dose–effect relationship was present at the participant level.

The development of peer-led services is one of the most effective approaches to promoting personal recovery. For example, stigmatising beliefs are difficult or impossible to maintain when a majority of employees are peers. Peer-led services have a very different feel to traditional mental health services. They communicate the message that the experience of mental illness shows the strength to have come through adversity, rather than being a sign of weakness. The central goal of peer-led services is to support people to re-engage in determining their own future. Our next case study is an example of a peer-run telephone support service.

Case study 6: Warmline

Warmline (Waea Mahana in Māori) is a free peer support telephone helpline staffed by peer volunteers (i.e. people who self-identify as users or ex-users of mental health services). It is run by the Non-Governmental Organisation Wellink (Te Hononga Ora) in Wellington, and is the first peer support phone service in New Zealand. It aims to help callers to work out their own solutions to their problems over time.

The Warmline service features include:

- Confidential peer self-help
- Someone to talk to when feeling sad, lonely, anxious or frightened
- It involves open sharing of feelings
- It gives time to talk to someone who has been there
- It promotes awareness of ways to help yourself
- It gives a chance to discuss a decision.

It is not a crisis line or clinical service, but referral on to another service is possible. Confidentiality issues are addressed explicitly, with advertising material containing the

Case study 6: (*cont.*)

statement 'Anything you discuss with a Warmline volunteer is confidential within Warmline except in exceptional circumstances. Warmline would only contact other services if they had your implied consent'.

The service has about 30 volunteers, and new people are recruited through adverts in local papers, encouraging people with experience of using mental health services to apply. Applicants can be people who have had no contact with mental health services for several years, or people for whom Warmline provides a supportive work-experience opportunity, as a stepping-stone back towards paid work, especially in the mental health sector.

Further information: www.wellink.org.nz

Peer-led services create opportunities for meaningful involvement, shown in our next case study.

Case study 7: Rethink garden project

This project started as an activity offered by the local day centre. A centre worker who was keen on gardening negotiated with the local council to work a disused allotment, one plot among about 50 on the site. Service users attending the day centre could opt to do gardening, and they and the mental health professional worked the allotment together. Following the closure of the day centre the charity Rethink took over the gardening project and around that time a discussion resulted in the garden becoming totally user-led and -run.

The quarter-acre plot houses a polytunnel, fruit cage and raised and flat beds within which grow an impressive variety of delicious herbs, fruit and vegetables, from rhubarb, melons and plump strawberries to aubergines, some splendid-looking asparagus and large vibrantly coloured peppers. The raised beds have been built for easy wheelchair access and for those who struggle to bend down. All woodwork including the raised beds, fruit cage and sign on the front gate has been made by members, everyone tending to work to their talents and expertise although ready to muck in with the less appealing jobs, such as weeding, as and when required. Members are motivated to spend time maintaining and caring for the garden partly because its survival depends upon their input, and in turn this sense of responsibility and achievement develops self-esteem and purpose. Caring for the garden is a positive responsibility because it is 'a self-imposed discipline rather than imposed by a doctor' or mental health team; 'there is no coercion' to be involved. The members' efforts are also rewarded materially; the fresh produce divided between them provides a welcome addition to the cooking pot.

There is a core group of four people and a larger peripheral group. Nowadays people are not 'sent' to garden from any of the local services but the users who work the garden hold barbeques and rely on word-of-mouth to recruit new members. The garden is entirely user-led, bestowing agency and control. Members come and go as they want, generally putting in a couple of 3–4-hour sessions per week. Decisions about planting are made together during a meeting held in the winter, but planning isn't exact and the garden evolves: members describe 'learning as we go along'.

The garden is considered by members as providing an activity, a 'focus' and a 'structure to the week', and not necessarily thought of as a therapy: 'it gives you something to do and you get something back from it'. Satisfaction is derived from thinking about and planning what can be achieved in the garden even at times away from the garden: 'I think about it before I go, I like the "problem solving" aspect'.

Confidence is developed from being part of a group and the mutual interest and common goal lead to strong friendships being forged; members often socialise together outside the

Case study 7: (*cont.*)

project. When at the garden, there is no association with mental health: 'you are not labelled', it is 'not threatening' in any way, members are just seen as fellow gardeners by the other people who have plots there and mental health is not talked about unless it comes up in conversation. Involvement in the garden gives 'people dignity', the founding member acknowledged: 'I'd be much the poorer without it'.

More recently the half-plot next to the vegetable plot has been turned into a semi-wild community garden with a pond. The idea is that local schools and voluntary organisations can visit the garden to learn about growing produce and local ecology whilst concurrently integrating members into the broader community.

Further information: www.rethink.org

The two most developed countries internationally in relation to peer-run programmes are the USA[359] and New Zealand[91]. For example,[293]: 'There has been a quiet revolution happening in New Zealand. While the rest of the country has been paying attention to other things, support services run by and for people with experience of mental illness have been developing. There are now at least thirty-five or more of them' (pp. 4–5). Our next case study describes one such service – the Light House in Napier, New Zealand.

Case study 8: The Light House

In 1994, a group of people with experience of mental illness, meeting in each other's homes, began working together to get funding and a venue. In 1996, The Light House opened as a consumer-run community centre. The service now employs over 25 staff, many part-time, with a strong sense of shared ownership.

The aims of the service are to inspire recovery and reconnect people, and to be proactive. The service provides a range of services, including peer support and peer advocacy. The Hassle Free Clinic is a free medical clinic run by a local doctor every fortnight. The Whatever It Takes service provides home support for people with the highest needs who have no hope of recovery without peer support, advocacy and help in the community.

However, the vision is wider: 'to take over, govern and deliver services in order to minimise the impact of mental illness on generations to come'. The Light House centre is also the headquarters for political action, pushing for consumer participation at every level of planning and funding mental health services. This has involved coordination of hundreds of complaints about mental health services, filling consumer representative roles on a new mental health advisory group, and lobbying and media exposure.

Further information: www.lighthousetrust.co.nz

We now turn to another type of relationship which can be a major pro-recovery influence: the relationship between the consumer and the mental health professional.

Professional relationships

The focus in this chapter is on the relationship between the professional and the person with mental illness – *how* the clinician and the service user interact and work together. *What* they do is covered later, in Chapters 15 to 21.

Types of clinician–consumer relationships

Different types of relationship between clinicians and service users are possible. These can be understood as lying on a spectrum. At one end, there is a **real relationship**, defined as[388]:

> the personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other and perceives the other in ways that befit the other.

A real relationship thus involves genuineness (being who one truly is, being non-phoney, being authentic in the here-and-now) and realism (perceiving the other in ways that befit him or her, rather than through a clinical or in other ways distorting lens). The importance of context is de-emphasised, and interpersonal authenticity is primary. This concept of a real relationship is long-standing[389], and not specific to mental health services.

In the middle of the spectrum of relationship types lie **partnership relationships**, which are defined by the mental health context and involve collaboration and joint working. Activation of both the expertise-by-training of the professional and the expertise-by-experience of the individual are necessary for a partnership relationship to be possible and to work.

At the opposite end lie **detached relationships**, which are highly context-based and involve therapeutic models. The relationship is filtered by the clinician through their particular model. A psychodynamic therapist will invoke concepts of transference and counter-transference to understand the relationship. A cognitive-behavioural therapist will understand the relationship in terms of interpersonal schema activation. A prescriber will use the relationship to assess symptomatology and compliance. The common features are that the discourse is driven by the clinician's agenda, and that assessment information flows from patient to clinician whereas expert knowledge passes from clinician to patient.

This spectrum broadly involves *being with* in a real relationship, through *doing with* in a partnership relationship, to *doing to* in a detached relationship. It is a spectrum rather than three distinct categories of relationship. For example, in Chapter 2 we identified that cognitive models emphasise collaboration and doing with the service user, and impose assumptions such as empiricism and giving primacy to rationality. So cognitive models are intermediate between partnership and detached relationships.

There is no best type of relationship – all can be of benefit and can involve high trust and alliance. The purpose of outlining this spectrum is to draw attention to the issue of power. A distribution of power lies at the heart of every relationship type. Power lies on a

continuum, which in a mental health context has been conceptualised by the New Zealand Mental Health Commission as running from neglect and abuse, through paternalism and tokenism, to partnership and, finally, self-determination[292].

Detached relationships locate the power to interpret, understand, define and ultimately control the experience of mental illness with the mental health professional. The underpinning belief is 'I know what will help you'. At worst (as described in Chapter 7) this promotes neglect and abuse, and at best paternalism and tokenism. Modern approaches to clinical work emphasise involvement, but this remains inherently token – involvement is on the mental health professional's terms, with little expectation or openness to change in the professional as a result of the relationship.

Partnership relationships differ in that they involve a sharing of power – the expertise-by-training of the professional and the expertise-by-experience of the person with mental illness. In a partnership relationship, at times the patient is the expert and the clinician learns from or is changed by the patient. This kind of relationship thus promotes genuine co-working, and sets a context in which self-determination can develop. Real relationships have the potential to more directly promote self-determination.

In traditional mental health services, the primary emphasis is on detached relationships, with some importance attached to partnership relationships. Real relationships are normally seen as unprofessional.

In a personal-recovery-focussed mental health service, the centre of gravity shifts, so that greater emphasis is put on partnership relationships, and both real relationships and detached relationships are legitimised. To understand this statement, we need to elaborate the differences between a detached relationship and a partnership relationship.

Detached and partnership relationships

A partnership relationship differs from a detached relationship in where the decision-making power lies.

In a detached relationship, the power to make sense of what is said, to summarise (e.g. as a diagnosis or formulation), to identify realistic goals and available treatment choices, and to plan care lies with the professional. Decision-making power is nominally shared, but in reality held by the clinician. A key marker of this type of relationship is the resulting care plan:

- It contains professional jargon rather than the words of the patient
- The plan targets amelioration of deficits rather than strengths on which to build
- The goals concern avoiding bad things happening more than making good things happen
- Responsibility for the resulting actions lies more with mental health staff than with the patient
- It is authored by the professional, rather than the patient, their family or an advocate
- Collaboration is nominally demonstrated by the signature of the patient, or the patient having a copy of the care plan
- The care plan rarely creates ethical, organisational or behavioural challenges for the mental health system.

In a partnership relationship the service user is the ultimate decision-maker, other than where legal issues over-ride. This does not always mean that the professional does what the person says; clearly a professional cannot act unethically, or collude with an individual in

damaging acts. But this is a quite different constraint to the paternalism discussed in Chapter 5. The basic orientation of a clinician in a partnership relationship is towards actively seeking to be led by the individual and their own wishes, goals and dreams[26]:

> Diagnosis becomes something other than the doctor defining the patient's world from the point of view of a detached expertise that arrives with its definitions and demarcations already in place. Instead, diagnosis becomes a process of exploration pursued by professional and patient together. It becomes an attempt to develop a framework of understanding and explanation that calls on different sorts of knowledge . . . The patient's own understanding of his/her world moves centre-stage.
>
> (pp. 133–134)

This shift in power is easier in some cultural contexts than others. Sociopolitical and professional expectations that the health professional will understand and treat illness are difficult forces for the individual clinician or patient to resist. It may be no coincidence that the country with the most developed approach to recovery-focussed mental health services is New Zealand, which also has the most deeply embedded partnership model of any English-speaking country in relation to indigenous people. The Tiriti o Waitangi (Waitangi Treaty) was a founding document of New Zealand, and laid down the participation rights of indigenous Māori and Polynesian Islanders. This laid the cultural foundation for Māori concepts such as Whānau Ora ('Māori families being supported to achieve their maximum health and well-being'[390]) becoming integrated into mental health services.

A partnership relationship also differs from a detached relationship in the nature of listening undertaken by the mental health professional. Although all clinicians would agree about the importance of listening to the patient, in a detached relationship the listening is done in order to make a careful assessment, to monitor mental state and to plan care. The professional may try hard to understand the person, to find meaning in their experiences, and to openly acknowledge points of agreement and difference. However, an orientation at the heart of a detached relationship is that listening is done in order to fit the person into the clinical model, and not the other way round. This is not of course always inappropriate, but it differs from a partnership relationship. An unfortunate consequence of this type of listening is that the person may not feel understood. Bracken and Thomas propose alternative guiding questions[26]: What does this person, and this family, need at this stage? How can we help this person cope with this crisis without a loss of dignity? How can we help this person avoid compulsory interventions? If the goal of interaction is to answer this type of question, then the patient's values and preferences and strengths need to be established. This requires a different kind of discourse.

For example, there are lessons about engagement to learn from non-health sectors. In Case study 17 we will consider how challenging behaviour is responded to in an education context. Another sector which has developed skills in engaging with people is the hospitality industry. Key values, such as the importance of welcome, the customer always being right and the job being to provide help to meet the customer's needs, underpin the best interactions in this service industry. Hospitality workers are skilled in recognising how customers like to be engaged with – from face-to-face to elbow-to-elbow. Workers are not doing their job if customer care is poor. In the same way, a partnership relationship involves a warm welcome (because that makes the whole interaction more positive), listening to understand what the person wants, and then working with the person to identify options to meet their goals. How the person feels they were dealt with – called satisfaction with care in a mental health context – is a central, not peripheral, indicator of success.

A partnership relationship involves the clinician acting in accordance with three principles.

1. The experience of mental illness is normally meaningful

Meaninglessness enhances stigma and alienation: the sense of being 'other'. Detached relationships do not always emphasise meaning and understanding[83]. An expectation of meaningfulness leads the clinician to look for meaning. We elaborate on this aspect in Chapter 16.

2. A clinical model provides one of many ways to make sense of experience

In Chapter 2 we argued that a clinical model provides one coherent way of making sense of the individual's experiences, but should be treated as a hypothesis rather than revealed truth. Human experience cannot – in contrast to Enlightenment assumptions – be grasped using a technical idiom. This point has been made eloquently by many others[40;391;392], although normally as a starting point for an elaboration of another theory of how things really are. In this book we move away from an Enlightenment value of taming chaotic reality through technical rationality, and reject the claims of any theory as universally valid or foundational. A partnership relationship requires that the clinician has modesty in relation to the universality of their own theory. A hallmark of a partnership relationship is therefore a focus on consensus. This is challenging, because it involves genuine listening and negotiation. For example, if the predetermined question which structures the clinical interaction is 'What medication/therapy to prescribe?', then the relationship will not be one of partnership. A partnership relationship will involve asking 'Do you want help? If so, what kind?' and providing the information to support decision-making.

There is also a pragmatic reason to be focussed on the perspective of the person with mental illness. This is summarised in a conversation between service users about psychiatric nursing practice[393]:

> I think a lot of the time their [i.e. nurses'] training doesn't let them realise that the consumers know a lot about themselves and if they just took the time to get to listen to people they would realise that we know a heck of a lot about what has worked and what hasn't worked and they could circumvent a lot of trauma if they would just use the expertise that the person has about themselves.
>
> (p. 25)

Empirical evidence is consistent with this perspective[394]. The patient experience of being treated with respect and involved in decision-making is more predictive of good outcomes than the staff rating[395].

3. Only the individual can define their own best interests

A central value, discussed in Chapter 5, is that the individual is the person who can best define their own interests, and the job of the mental health professional is to support this process. This involves validating a service user who decides that their pathway to recovery lies only partly in, or totally outside, the mental health system.

Expertise-by-experience is highly valued in a partnership relationship. It comes closest to the essence of mental illness: subjective experience. What the person says may of course not accurately reflect their inner world: the experiences may not be expressible in words; they may not yet have processed the experiences sufficiently to be able to reflect on and describe them; or they may not trust the person asking them. But what people say, or otherwise

communicate such as through art or poems, provides the best available approximation to their inner world. Lived experience is necessary because[128]: 'people with psychiatric disabilities – just like all those who do not have psychiatric disabilities – are the experts on the topic of their own experiences, needs, and preferences, and thus are best able to identify what would be helpful – or not – in promoting their own recovery'. When combined with the expertise of competent clinicians, this has the potential to ensure a power balance in the relationship because both clinician and patient contribute their own expertise. This synergy is captured in the TEAM acronym – Together Everyone Achieves More.

A term used to describe this type of partnership relationship is **mutuality** – the view that we have all recovered from challenges, and that it is helpful to emphasise this commonality[360]. The best recovery support occurs when the expertise of the professional and the self-knowledge of the individual are both given importance. Mutuality involves flexibility on the part of the professional and the service user. The professional needs to show modesty and humility about the universality of their clinical model, be prepared to work alongside and therefore be more exposed to the person, and to see their job as providing choices rather than fixing the problem. The service user needs to manage the anxiety and do the work associated with taking responsibility for one's own life, and learn to engage and do things that may involve risks and failures. Mutuality also involves both giving and receiving, so the clinician may be challenged, influenced and changed by the person – again emphasising commonality over difference.

Two key differences between detached and partnership relationships have been identified: power and listening. Partnership relationships have several advantages over detached relationships in relation to personal recovery: they generate hope; facilitate the development of meaning rather than imposing a clinical model; and support the service user to take personal responsibility.

Markers of a partnership relationship include:

1. At the team level, there is a concordance between what is said to the person and what is said about them. This is why unhelpful statements made within teams about people with mental illness should be appropriately challenged – not as politically correct point-scoring, but as a means of establishing, maintaining and owning a consistent set of values in the service.

2. It is acceptable for individual clinicians to discuss their own experience of mental health problems. This challenge to the them–us distinction implicit within detached relationships is only possible where there is genuine rather than nominal value placed on lived experience.

3. There is honesty about agreement and, more challengingly, disagreement between clinician and service user. Acknowledging difference is the bedrock of partnership, since it allows genuine collaboration between the professional with their expertise and the service user with theirs.

4. There is honesty about the power to change a situation. Although it gives short-term relief to promise cure, in the longer term it creates resentment and disillusionment with the system[4]. Sometimes a powerful antidote to the tendency towards a detached relationship, with its implicit expectations of cure through action by the clinician, is for an experienced mental health professional to admit 'I don't know', and to focus instead on their own commitment to supporting the person to take responsibility for their life.

The potential pay-offs are high. Partnership relationships characterised by collaboration and negotiation are associated with higher uptake of medication[253;255], lower 20-month

hospitalisation rates[396], better prediction of in-patient violence during hospitalisation[397], and improved outcomes such as quality of life, symptoms and functioning in depression[398], schizophrenia[399] and case management[395].

Busy clinicians might argue that a partnership relationship is nothing new – the problem is resources, not willingness. Detached relationships take less time to develop and maintain than partnership relationships. If the mental health system is over-run with demands, then it may simply not be possible to offer anything other than a detached relationship.

This is true, so far as it goes. If the goal of mental health services is primarily to promote personal recovery, and if this is only possible where services are structured to support partnership relationships (with all the implications for more meeting time and greater staff continuity), then system structures may need to change. Although this is a comforting view, in the sense of absolving individual clinicians from the need to change, it is challenged in two ways.

First, the service user perspective is that partnership is not always experienced as the basic orientation in clinical encounters. In New Zealand, service users stated[292]:

Mental health professionals need to KNOW that:
- we are individuals with unique experiences
- we respond well to being treated with respect and accorded our basic human rights
- we respond well when we are listened to and understood (even when we are scared and angry)
- we respond well to having our concerns taken seriously. For example, when our concerns about medication side-effects are properly addressed
- our health improves more quickly if we are calmed rather than restrained
- we can manage our illness better if we are educated about it
- we can manage our illness better if we are given some help in identifying the issues in our lives that cause us stress
- we find it easier to manage our illness if we know about the kind of support groups that are available in the community
- we can participate more fully in the community if we are given some assistance with our social needs
- we can be assertive in our communities if we know our rights

(p. 45)

Second, working in a way which supports recovery is about more than resources (e.g. of time). Changing clinical focus from 'Why the system won't change' to 'What I can do' mirrors the consumer's journey from an entitlement to an empowerment perspective, which is at the heart of a recovery approach.

The writings of people who are in recovery from mental illness indicate that, sometimes, the critical contribution of a mental health professional occurs when there are elements of a real relationship. For example, this balance is noted by Ian Light, a mental health service user and academic lecturer[307]: 'In my own history of mental health service use, the nurses who have been most help to me have been those who have had the ability to respond both humanely and professionally to my distress' (p. 7). We turn now to what this means.

Real relationships

Working with a recovery focus challenges current conceptualisations of professional behaviour. In a real relationship, professionals relate to the individual exclusively as a person, and not at all as a person defined by mental illness. The next case study illustrates one approach

to supporting real relationships in an acute in-patient mental health setting, and shows that there is no inherent contradiction between a therapeutic model (psychodrama, in this case) and a real relationship.

Case study 9: in-patient psychodrama group

Two one-hour sessions are held each week on the in-patient unit (in addition to one-to-one work using the psychodramatic framework with individual clients). The group is led by a psychodramatist (a psychotherapist trained in psychodrama). Each group involves a warm welcome from the director, clarifying of ground-rules, creation of a safe space to disclose, giving opportunities to all members to participate, and managing of time and emotional levels – all standard characteristics of a therapeutic group.

The group uses the psychodramatic framework[a]. Props are sometimes used to concretise – to develop an understanding about what's going on, to experiment with different and more adequate responses, and to develop more flexibility in relationships. Standard psychodrama techniques are used: doubling, role reversals and mirroring.

The key difference from most in-patient groups is that this group warms up both staff and patients to coming into the group as people first, in all their different roles. This means that staff in particular are asked to 'drop' their professional role and participate without differentiation. This creates a culture of 'we' rather than 'I–them', consistent with the psychodrama view that role-development is for everyone – we can *all* learn and grow from our encounters with each other.

The psychodrama group contains several elements that promote personal recovery:

- The language used by the director is non-pathological – the concept of lifefulness is frequently evoked, which differentiates between simply coping with adversity and embracing life by developing more adequate and engaging responses. This breaks down the stigmatising them-and-us implication of psychopathology language.
- Either the staff or the patient can bring their own issue and participate as the central actor, exploring and developing new approaches to responding. This has many benefits. It provides authentic role models for patients. It presents a human side of the professional. It fosters mutual respect between staff and patient, as both see the other as struggling to develop more adequate responses. Finally, it reduces the shame often experienced by patients about not being able to 'cope' – unlike most group situations, the boundary between participants who are coping and not coping is permeable.
- Metaphors for movement abound, starting with the greeting 'How are you travelling?'. This positions the group as process-focussed not outcome-focussed. It is not about obtaining the state of 'being better', but rather about the process of recovery.
- The group focus on the here-and-now. The founder of psychodrama, Jacob Moreno, said that the most important people in one's world are those who are in the immediate moment of the 'here-and-now'. This creates an invitation to come together and relate, which in turn positions what's going on in the group as real, supporting authenticity (being a person) rather than interpretation of transference (being a professional) in the relationship. This concords with consumer calls to 'be believed' when talking with professionals.
- A central theme is about trusting in your own creative genius. This makes explicit the view of the person as self-righting and having their own potent resources to find a way forward in their own life. It positions the actor as having responsibility for change, and gives permission to experiment and have fun. This contrasts with the passivity-inducing, risk-avoiding, humourless associations of traditional in-patient mental health services.
  Further information: Lorraine Michael (lorraine.michael@svhm.org.au)

Note:
[a]Moreno JL. *Psychodrama*. Vols 1-3. New York: Beacon Press; 1972.

This change in relationship complicates decision-making about how to respond to attempts by the patient to move outside their prescribed role. The traditional clinical view is that this constitutes a boundary issue, and the professional response involves maintaining the boundary. Unfortunately, the implicit message in this strategy is to reinforce the role of patient. Boundaries evolved to protect service users, and this of course remains important. But we now know that many stories of recovery identify the contribution of staff who broke professional rules. For example[400]: 'After I worked for a month she gave me a rose' [gift from clinician to client]; 'Last month when I didn't have any money left, she let me borrow 100 crowns until the end of the month' [lending client money].

On the basis of qualitative interviews with 15 service users, Borg and Kristiansen identify five working practices which support recovery: conveying hope; sharing power; being available when needed; openness about the diversity of what can be helpful; and a willingness to stretch the boundaries of a professional role[401]. This last component is perhaps the most challenging. Examples given in their study included receiving gifts from patients, lending money and seeing the patient when off-duty. Of course, these can all be exploitative staff behaviours, so one approach is universal prohibition. But we are confronted by the reality that some patients experience rejection when we refuse a gift, however gracefully. What is needed when an expected cheque has not arrived is a loan of money. A small kindness of extra time goes a long way. How can professionals use this fact in their clinical work, whilst still acting ethically?

Reconstructing professionalism

Legitimising behaviours which lead to these kinds of benefit will involve re-negotiating the social construction of a professional relationship. Two approaches are to re-frame professional behaviour and to develop more individualised approaches to decision-making.

Alain Topor takes the first approach[402], by distinguishing between the two types of professionalism shown in Table 13.1.

The dangers of engaged professionalism are inappropriate boundary violations, such as financial or sexual or emotional exploitation. However, the dangers of detached professionalism are impeding recovery by keeping people in the patient role, and disempowering them by imposing and reinforcing a deficit-focussed discourse. Curtis and Hodge suggest that 'greater damage may be done by rigid enforcement of professional distance'[403] (p. 24) than by boundary violations.

The MHA Village (www.village-isa.org) takes the second approach. They identify five criteria to be considered in deciding how to respond to the requests of members:

1. Ethical considerations – is the response exploitative?
2. Staff role – is the person competent to do the action, does the action fit within their role?
3. Member preference – is this something that the member wants?

Table 13.1 Characteristics of two types of professionalism

	Detached professionalism	Engaged professionalism
Time	Scheduled	Variable
Place	Predetermined	Flexible
I am … about my values and beliefs	Neutral	Explicit
Relationship	One-sided	Reciprocal

4. Staff preference – is the something the member of staff wants?
5. Clinical considerations – are there clinical reasons which over-ride other concerns.

In either approach, the consistent theme is that decision-making is explicit and visible – clinical supervision and team discussions make what would traditionally be an unethical professional response appropriate *for some people some of the time*. Sometimes, it is helpful to the person to have a hug, to have a lift, to know about the professional's spiritual beliefs, to give a token of thanks. Just like the issue of compulsion in the person's best interest discussed in Chapter 5, we cannot know for sure how to respond. The optimal approach avoids invariant solutions (e.g. No hugging, ever. No accepting of gifts, ever). We can simply do our best by exercising judgement.

That said, rule-breaking creates anxiety, whatever the motive. Staff want of course to not leave their behaviour open to question, for both benevolent and self-interest reasons. However, in a recovery-focussed service, there are changes in some expectations about behaviour. For example, there is less social distance between patients and staff, and patients are encouraged to take positive risks (see Chapter 20). The anxiety generated by these changes needs to be held by the system, not by individual workers within the system. A reasonable set of expectations is that staff responses are informed by:

1. An explicit values base, which the clinician can identify and apply
2. An understanding of the real (rather than constructed through custom-and-practice) non-negotiables: legislation, policy and professional codes of conduct
3. A belief that ethical challenges have individual rather than invariant solutions
4. An expectation that ethical dilemmas are discussed in teams and supervision rather than being individually resolved – with no licence whatsoever to covertly act outside accepted professional norms.

A means of recording the discussion and decision for future inspection is of course necessary.

A professional relationship

Working in a recovery-focussed way involves change for the professional. For example, the clinician's role as an expert is less prominent. The expert role implicit in a detached relationship remains as an important tool in the professional armoury. It is unhelpful to put expectations on a person who is still early in their recovery journey (what a professional might call acutely unwell) which they cannot even begin to meet. Sometimes people want an expert view – about diagnosis, prognosis and treatments. People who want to understand their experiences as a mental illness have a right to know the professional's opinion about what is wrong with them and what might help. We discuss this in Chapter 16. Similarly, sometimes people have lost the ability to look after themselves, and in the absence of any better option need an expert to provide guidance and to intervene, with compulsion when necessary. We explore this further in Chapter 21.

However, and it is a big however, in mental health services this should be one of many styles of interaction. In a service focussed on supporting personal recovery, it is likely that expert-style clinician–patient interactions will be the exception rather than the rule. Other interactional styles will more often be helpful and beneficial. It is noteworthy that the emphasis in evidence-based practice on *what* is to be done implicitly de-emphasises a focus on *how* it is done.

Raising awareness about clinician roles is a necessary first step towards reflective practice. Larry Davidson and colleagues identify established types of clinical roles which

follow from alignment with different theorists, including as detective (Sigmund Freud), cultural anthropologist (Carl Jung), cheerleader (Carl Rogers), teacher (Aaron Beck), social control agent (E. Fuller Torrey) and (paid) friend (Peer Support Movement)[404]. A specific role which is prominent in a recovery-focussed service is as a coach[405]. In Chapter 12 we described this role for peers. For professionals, the advantages of a coaching approach are:

1. It assumes the person is or will be competent to manage their life. The capacity for personal responsibility is a given.

2. The focus is on facilitating the process of recovery to happen, rather than on the person. Coaching is about how the person can live with mental illness, and differs from a clinical focus on treating the mental illness.

3. The role of the coach is to enable this self-righting capacity to become active, rather than to fix the problem. This leads to amplification of strengths and natural supports, rather than of deficits.

4. Effort in the coaching relationship is directed towards the goals of the coachee, not the coach. The skills of the coach are a resource to be offered. Using these skills is *not* an end in itself.

5. Both participants must make an active contribution for the relationship to work.

Since clinical expertise is hard-won through years of training and supervised practice, being asked to let go of an expectation that this expertise will be given primacy is painful. More deeply, there is the challenge for the clinician of being asked to shift from a role as the person without problems towards a relationship involving two people struggling together to help one move on in their life. This transition requires emotional maturity and resilience. Competent clinical supervision is a key requirement for supporting pro-recovery practice. Professionals who do not feel they need clinical supervision are probably using automated and non-reflective problem-solving approaches in their work with clients, which is not consistent with an individualised recovery-focussed approach. The uncomfortable reality is that working to promote recovery will more often require professionals to reflect on their own values, boundaries and beliefs.

Real relationships are sometimes necessary for the reasons outlined above, but people come to mental health services wanting professional help, not just another human to have contact with. Detached relationships are also sometimes necessary, e.g. for people in the early stages of recovery, or where there are over-riding legal necessities. But detached relationships involve giving primacy to clinician imperatives. The centre of gravity in a recovery-focussed service is partnership relationships, in which the interaction is embedded in a clinical context.

Clinical expertise remains central to this type of relationship, although it is deployed to support self-management. The shift towards partnership relationships is not then a licence for the clinician to work less hard, or to abandon more easily, or to provide unfocussed or non-evidence-based treatment. It involves the use of clinical expertise in a different way. Larry Davidson and colleagues identify some of the lessons which mental health professionals will need to learn if they are to function as recovery guides[404]:

> Regardless of whether or not he or she sought your help, recognize that the client had already embarked on his or her own journey before meeting you . . . Your credibility and effectiveness as a recovery guide are enhanced to the degree that you are familiar with, and can anticipate, interesting sites, common destinations, and important landmarks along the way. . .Guides prepare for the journey by acquiring tools that will be effective in addressing or bypassing symptoms and other sequelae of the illness that act as barriers to the client's recovery.

(pp. 490–494)

This chapter is about the promotion of hope through relationships with professionals. These relationships provide one context in which hope can blossom, but the relationship itself is often insufficient – action is needed. The remaining chapters in this section are more concerned with the content of actions to promote recovery than with the relationship with the professional. Before coming to approaches to assess, plan and implement actions, and consistent with the recovery orientation of giving primacy to the person not the illness, we start with the promotion of well-being.

Promoting well-being

In this chapter, we apply insights from the academic discipline of positive psychology, to suggest some approaches to promoting well-being in people with mental illness.

What is positive psychology?

Positive psychology is the science of what is needed for a good life. This is not a new focus – proposing qualities needed for a good life is an activity dating back to Aristotle's investigation of *eudaimonia*. But the emergence of a scientific discipline in this area is a modern phenomenon. Martin Seligman, often identified along with Mihaly Csikszentmihalyi as the founders of the discipline, suggests a definition[406]:

> The field of positive psychology at the subjective level is about valued subjective experiences: well-being, contentment, and satisfaction (in the past); hope and optimism (for the future); and flow and happiness (in the present).
>
> At the individual level, it is about positive individual traits: the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future mindedness, spirituality, high talent, and wisdom.
>
> At the group level, it is about the civic virtues and the institutions that move individuals toward better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic.

Findings from positive psychology are important to mental health services because its focus is as relevant to people with mental illness as to people without mental illness. Positive psychology is specifically relevant to personal recovery. Factors identified by consumers as important for their recovery include hope, spirituality, empowerment, connection, purpose, self-identity, symptom management and stigma[135]. All but symptom management were entirely absent from my professional training both as a clinical psychologist and – in the distant past – as a mental health nurse. Nor do they strongly feature in the training of other mental health professions[292]. By contrast, the concordance between the science of positive psychology and these priorities identified by recovered consumers first fuelled my interest in the applicability of positive psychology to supporting personal recovery. At least the focus of this science is pro-recovery.

An influential framework is Seligman's theory of Authentic Happiness, which identifies different types of good life[407;408]:

1. The **Pleasant Life**, which consists in having as much positive emotion as possible and learning the skills to prolong and intensify pleasures
2. The **Engaged Life**, which consists in knowing your character (highest) strengths and recrafting your work, love, friendship, play and parenting to use them as much as possible

3. The **Meaningful Life**, which consists in using your character strengths to belong to and serve something that you believe is larger than just your self

4. The **Achieving Life**, which is a life dedicated to achieving for the sake of achievement.

This framework points to the possibility of different types of good life – which means that a range of approaches to promoting well-being are needed. We will explore some of these approaches in this chapter.

Research centres are developing internationally, shown in the Appendix. Academic compilations of the emerging empirical evidence[409;410] and accessible introductions to the theory[411;412] and its applications[413] are becoming available. Three illustrative strands of work will be described, which are particularly relevant to personal recovery.

Illustrative strand 1: mental health and recovery

A central assertion in the positive psychology literature is that mental health is more than the absence of mental illness – they are not two ends of a single spectrum. Mental health is a distinct dimension from mental illness. This is not of course an original observation: the World Health Organization defines health as[414]:

> A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

And mental health as:

> A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

This distinction between mental illness and mental health is empirically validated, with only modest correlations between measures of depression and measures of psychological well-being, ranging from -0.40 to -0.55[415;416]. A more statistically robust approach is a confirmatory factor model, which showed that the latent factors of mental health and mental illness in a US sample ($n=3032$) correlated at 0.53, indicating that only one quarter of the variance between measures of mental illness and mental health is shared[417].

Why is this distinction important? Because it points to the need to support both the reduction of mental illness and the improvement of mental health. A conceptual framework is provided by the Complete State Model of Mental Health[418], proposed by Corey Keyes, and shown in Figure 14.1.

This model identifies two dimensions. Mental illness lies on a spectrum, from absent to present. Well-being also lies on a spectrum, from low to high. This conceptual framework provides a better match with the values of recovery. A perennial question about recovery is 'How can you be recovered if you still have the mental illness?'. Whatever answers are given (and there are many – see Chapters 24 and 25), they can be only partial answers since the term recovery is an illness term. By contrast, access to mental health is open to all. This provides an alternative frame of understanding for recovery:

> **Personal recovery** involves working towards better mental health, regardless of the presence of mental illness

People with mental illness who are in recovery are those who are actively engaged in working away from Floundering (through hope-supporting relationships) and Languishing (by developing a positive identity), and towards Struggling (through Framing and self-managing the mental illness) and Flourishing (by developing valued social roles).
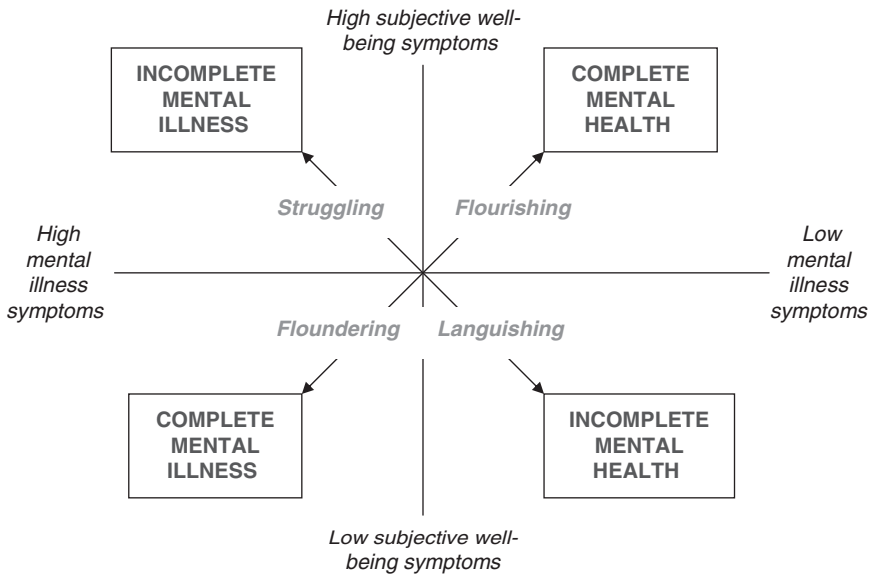
Figure 14.1 The Complete State Model of Mental Health.

This concept of mental health has been operationalised into 13 dimensions, across the domains of emotional well-being, psychological well-being and social well-being[417;419]. These dimensions have been empirically validated[415;420], and are shown in Table 14.1

Like mental illness, the concept of mental health can be expressed as a syndrome. Using the same diagnostic framework as DSM uses for major depression, the condition of Flourishing is defined as requiring high levels in Dimensions 1 (Positive affect) or 2 (Avowed quality of life) to be present, along with high levels on at least six of the 11 dimensions of positive functioning (Dimensions 3 to 13). Similarly, to be diagnosed as Languishing, individuals must exhibit low levels on one of the emotional well-being dimensions, and low levels on six of the remaining 11 dimensions. Adults who are neither flourishing nor languishing are said to be moderately mentally healthy. Finally, complete mental health is defined as the absence of mental illness and the presence of flourishing.

What is the prevalence of mental health, using these definitions? A cross-sectional assessment in the US population[419] (n=3032) is shown in Table 14.2.

A similar US study of youth (n=1234) found 6% of 12–14-year-olds Languishing, 45.2% with Moderate Mental Health, and 48.8% Flourishing, with respective proportions of 5.6%, 54.5% and 39.9% in 15–18-year-olds[421].

These results have two profound implications. First, careful consideration should be given to the balance between research into mental illness and mental health. Among US adults with no mental illness, one in 10 are languishing and fewer than 2 in 10 are flourishing. The implicit expectation that research into mental illness will promote mental well-being is neither empirically justified nor a cost-free assumption – the opportunity costs for an illness-dominated research agenda may be high. For example, Flourishing is aligned with concepts such as self-righting, self-efficacy and mastery as characteristics which critically impact on the ability to self-manage. As Keyes puts it[417]:

> In particular, is languishing a diathesis for, and is flourishing a protective factor
> against, the onset and recurrence of mental illness? Conceptually, one can think of

Table 14.1 Operationalisation, definition and examples of three domains of mental health

Domain	Dimension	Definition	Example
Emotional well-being	1. Positive affect	Regularly cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life	I feel happy and engaged in life most of the time
	2. Avowed quality of life	Mostly or highly satisfied with life overall or in domains of life	My life is good, and I wouldn't change it
Psychological well-being	3. Self-acceptance	Holds positive attitudes toward self, acknowledges, likes most parts of self, personality	When I look at the story of my life, I am pleased with how things have turned out so far
	4. Personal growth	Seeks challenge, has insight into own potential, feels a sense of continued development	For me, life has been a continuous process of learning, changing and growth
	5. Purpose in life	Finds own life has a direction and meaning	Some people wander aimlessly through life, but I am not one of them
	6. Environmental mastery	Exercises ability to select, manage and mould personal environs to suit needs	I am good at managing the responsibilities of daily life
	7. Autonomy	Is guided by own, socially accepted, internal standards and values	I have confidence in my own opinions, even if they differ from most other people
	8. Positive relations with others	Has, or can form, warm, trusting personal relationships	People would describe me as a giving person, willing to share my time with others
Social well-being	9. Social acceptance	Holds positive attitudes toward, acknowledges and is accepting of human differences	I believe people are kind
	10. Social actualisation	Believes people, groups and society have potential and can evolve or grow positively	The world is becoming a better place for everyone
	11. Social contribution	Sees own daily activities as useful to and valued by society and others	I have something valuable to give to the world
	12. Social coherence	Interested in society and social life and finds them meaningful and somewhat intelligible	I find it easy to predict what will happen next in society
	13. Social integration	A sense of belonging to, and comfort and support from, a community	My community is a source of support

mental health as the continuum at the top of the cliff where most individuals reside. Flourishing individuals are at the healthiest and therefore farthest distance from the edge of this cliff; languishing places individuals very near the edge of the cliff. Hence, languishing may act as a diathesis that is activated by stressors that push individuals off the cliff and into mental illness.

(p. 547)

There is empirical support for this proposition. One validated approach involves training for optimism, by modifying the three components of explanatory style (permanence, pervasiveness, personalisation) through transforming negative thinking into positive cognitive processes that promote flexible thoughts and resilience. A study involving 70 children at high risk of depression showed that this technique reduced depressive symptomatology

Table 14.2 Prevalence of mental health and mental illness

Condition	Prevalence (%)
Mental Illness and Languishing	7
Mental Illness and Moderately Mentally Healthy	15
Mental Illness and Flourishing	1
Languishing (and no mental illness)	10
Moderate Mental Health (and no mental illness)	51
Complete Mental Health (Flourishing, no mental illness)	17

and lowered incidence rates at 2-year follow-up[422]. In a mental health service context, there is also emerging evidence that positive life events are important protective factors[330]. A study of 260 people with severe mental illness showed that an increasing ability to engage in pleasurable activities leads to the ability to regulate depressive symptoms to the point where they did not impact on identity by eroding self-esteem[423].

The second implication is that it is possible to be moderately mentally healthy, or even flourishing, despite the presence of ongoing mental illness. In other words, personal recovery is possible even in the presence of current symptoms. Cook and Jonikas label this process as thriving, in which individuals rebuild lives with qualities better than before their difficulties began[424]. Interventions which support the individual in moving towards mental health may be as important as interventions which address the mental illness.

Illustrative strand 2: hope

Hope is identified by many consumers as the starting point for their own recovery. Zlatka Russinova proposes that hope comprises three elements: perceived external resources, perceived internal resources and positive expectations[425]. She notes that generating hope in others requires a clinician to believe that such hopefulness might be justified.

From a psychological perspective, hope has progressed from meaning an overall perception that goals can be met to the more operationalised Hope Theory of C. Rick Snyder, in which hope is conceptualised as a bidimensional construct, comprising agency and pathways[426]. Agency (or a sense of will-power) involves the determination needed to begin and maintain the effort needed to achieve goals. Pathways (or a sense of way-power) involves belief in one's ability to generate successful plans, and alternatives when obstacles are met, in order to meet desired goals.

Hope is different to optimism – it involves not only positive expectancies and specific goals of agency, but also the flexibility to respond to obstacles by changing goals or methods. This distinction is illustrated by the response of Admiral Jim Stockdale when asked which people did *not* survive the Vietcong prisoner-of-war camps[427]: 'Oh, that's easy. It was the optimists. They were the ones who said we were going to be out by Christmas. And then they said we'd be out by Easter and then out by the Fourth of July and out by Thanksgiving, and then Christmas again . . . You know, I think they all died of broken hearts' (p. 48).

An intervention based on Hope Theory has shown beneficial impact. The intervention focussed on setting and working on reasonable goals, discussing the process and using homework, with the goal of increasing the production of pathway and agency thoughts. When tested as a group therapy with depressed older adults, hopelessness and anxiety reduced, hope increased and (in comparison with a reminiscence therapy control) depressive

symptomatology was reduced[428]. A 5-week hope-focussed orientation group for people starting to use a community mental health centre led to benefits in relation to well-being, functioning, coping and symptomatology, especially for clients with lower initial hope[429].

This is relevant to mental health practice, because people with high hope are more likely to have positive expectations that they can cope with future adversity[430], and indeed hopefulness moderates the relationship between unanticipated stressors and successful coping[431]. Clinical implications emerging from this research are the importance of using coaching[405] and cognitive therapy skills to help people find alternative goals when faced with goal blockage (rather than unproductively ruminating)[432], and the need to help the person develop a supportive network of high-hope confidantes to whom they can turn for advice[433].

Illustrative strand 3: flow

The positive psychology literature has addressed the question of how to lead an engaged life. A key emergent concept is flow, which Nakamura and Csikszentmihalyi identify as requiring two conditions[434]:

(a) Perceived challenges that stretch (i.e. neither over-match nor under-utilise) existing skills – a sense that one is engaging challenges at the level of one's capacities

(b) Clear proximal (short-term) goals and immediate feedback on progress.

They define being **in flow** as:

> the subjective experience of engaging just-manageable challenges by tackling a series of goals, continuously processing feedback about progress, and adjusting action based on this feedback

(p. 90)

In terms of flow, a good life is one that involves complete absorption in what one does.

Flow is an important concept for mental health professionals to understand, since it is the structural opposite of positive emotion. Flow is a subjective experience, but unlike positive emotions it is not defined by feelings. Rather, it results from doing activities we like. Indeed, 80% of people report that when in flow, feelings and thinking are temporarily blocked[434]. This means that **feeling good is not always necessary for a good life**. Consequently, an automatic focus on taking away experiences of unhappiness (such as symptoms of depression) may be counter-productive. It is possible to experience authentic happiness by living a meaningful life that comes through full engagement. This of course has implications for how mental health services work – the goal may not be to help the person to feel better, but to re-engage in their life. What this means for mental health services is that a *central* challenge is supporting reasonable goal-setting and goal-striving. These goals need to be:

1. *Personally relevant, rather than meeting the needs of staff*

There may of course be other reasons for staff-based care planning, but care plans focussed on clinical risk, medication compliance, relapse prevention and symptom reduction will not promote personal recovery.

2. *The right level of challenge*

The concept of a reasonable goal captures the balance in setting goals which are neither too easy (leading to boredom and distraction) nor too difficult (leading to anxiety and heightened self-awareness). A good life is not achieved by simply lowering expectations, as commentators from both left-wing politics (who want more justice) and right-wing politics (who want more excellence) have noted[435]. But nor is it achieved by raising expectations too high – recovery should be a journey, not a tread-mill.

3. *Proximal rather than distal*

Short-term goals provide more opportunity to become engrossed in the experience, and make engaged goal-striving more likely.

4. *Structured so that feedback is immediate and authentic*

It is this immediate feedback loop that promotes full attentional awareness on the challenge.

One approach to increasing well-being is therefore to support personally relevant goal-setting and goal-striving activity. This approach is used in the Collaborative Recovery Model.

Case study 10: Collaborative Recovery Model

The Collaborative Recovery Model (CRM)[a] is a staff training programme, based on the principles of positive psychology and its derived coaching practices. The training comprises two one-day workshops followed by one-day booster sessions six months and one year later. The content aims to develop skills in promoting autonomy and self-determination, and in creating a recovery vision – in other words, to help staff to use evidence-based skills to promote personal recovery. It is organised into six modules – two on guiding principles and four on specific skills.

The first guiding principle is a focus on personal recovery, identifying the centrality of hope, identity, meaning and personal responsibility[b]. The second guiding principle is collaboration and autonomy support. The importance of collaboration is underpinned by the empirical evidence linking working alliance with positive outcomes. Autonomy support means assisting people to make *their own* choices and is derived from self-determination theory, which recognises that being autonomous does not mean being isolated or independent of others[c].

The skills modules are:
1. Change enhancement using motivational interviewing
2. Collaborative needs assessment, to identify unmet needs
3. Collaborative goal-setting and striving, comprising the development of a personal recovery vision and identification of measurable, important and potentially attainable 3-month goals to progress towards the vision
4. Collaborative task assignment (referred to as homework) and monitoring, comprising review, design and assignment, along with development of strategies for overcoming identified obstacles.

Overall, the approach teaches the goal-striving cycle using what is called Collaborative Goal Technology[d]. It is based on adult learning principles, which are not specific to mental health, and therefore provide a normalising framework. The focus on goals provides a practical approach to improving hope, since goals require hope. A key training point is an awareness of the balance between meaning and manageability[e] – personally more meaningful goals are associated with lower manageability in people who currently lack self-efficacy (as is common in mental illness). Separating distal goals (the personal recovery vision) from more proximal goals (the 3-month plan) has three advantages. First, more proximal goals tend to have higher manageability. Second, the presence of the distal goal increases meaning for the proximal goal – commitment is higher because plans are for a purpose which is important to the consumer. Third, it supports staff engagement in the proximal goal (e.g. 'I will not be in bed during the day'), even if the distal goal (e.g. 'I will run my own business') appears to the clinician to be unrealistic.

Further information: Lindsay Oades (loades@uow.edu.au)

Notes:
[a]Oades L, Deane F, Crowe T, Lambert WG, Kavanagh D, Lloyd C. Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry* 2005; **13**(3):279–284.

Case study 10: (*cont.*)

[b]Andresen R, Oades L, Caputi P. The experience of recovery from schizophrenia: towards an empirically-validated stage model. *Australian and New Zealand Journal of Psychiatry* 2003; **37**:586–594.

[c]Sheldon KM, Williams G, Joiner T. *Self-Determination Theory in the Clinic: Motivating Physical and Mental Health.* New Haven: Yale University Press; 2003.

[d]Clarke SP, Oades LG, Crowe T, Deane F. Collaborative goal technology: theory and practice. *Psychiatric Rehabilitation Journal* 2006; **30**(2):129–136.

[e]Little BR. Personal project pursuit: dimensions and dynamics of personal meaning. In: Wong PTP, Fry PS, eds. *The Human Quest for Meaning: A Handbook of Research and Clinical Applications.* Mahwah, NJ: Lawrence Erlbaum; 1998. 193–235.

The approach emphasises key recovery values of autonomy and self-determination[436], and builds on an established evidence base around personal goal-setting and goal-striving[437]. Preliminary evaluations of CRM are positive, showing improvements in staff attitudes (e.g. hopefulness) and knowledge[438]. A 10-site randomised controlled trial across three Australian states is under way.

We now consider more directly the implications of positive psychology research for promoting well-being in people with mental illness.

Interventions to promote well-being

What interventions increase levels of well-being or amplify existing strengths?

Cognitive behavioural therapy (CBT)

This psychological intervention will be familiar to most clinical readers, so no introduction will be given. Competently provided CBT is aligned with many elements of promoting recovery and personal well-being:

- It has the flexibility to be focussed on personally valued goals, rather than service-valued goals
- Responsibility for change lies with the patient, not the therapist
- A key therapeutic strategy is the development of meta-cognitive awareness – an awareness of thoughts being distinct from self. This creates the context in which a positive identity can flourish, despite the presence of ongoing symptoms of mental illness
- It trains self-management skills and reinforces interdependence and independence rather than dependence, leading to sustained gains after the end of the formal therapy
- The emphasis on homework, reality testing and learning opportunities contributes to keeping the person in their life
- If unhappiness is caused by a mismatch between self and ideal-self images, then CBT has the potential to focus on the environmental reality as much as the personal interpretation of experience. This reduces the distortion due to a focus on intrapsychic assessment, and allows (although this is not yet fully exploited in current CBT approaches) action planning around changing the environment.

Mindfulness

Meditation is 'a family of techniques which have in common a conscious attempt to focus attention in a non-analytical way, and an attempt not to dwell on discursive, ruminative thought'[439]. Teaching meditation to members of the public increases self-reported

happiness and well-being, changes which are corroborated by healthier EEG readings, heart rates and flu immunity[440].

Meditation has been applied to mental health issues, such as anger[441] and – in the form of mindfulness-based cognitive therapy (MBCT) – depression[442]. Mindfulness is a form of meditation which involves attending non-judgementally to all stimuli in the internal and external environment but to avoid getting caught up in (i.e. ruminating on) any particular stimulus. Mindfulness requires a different mind-set to the quick-fix of a magic pharmacological or psychological bullet. Just as becoming a top-class violinist requires 10 000 hours of practice with a competent teacher[443], so too mindfulness needs to become a way of life if it is to transform identity. It involves changing habits:

- enhancing meta-cognitive awareness by noticing what one is thinking about
- developing the ability to urge-surf by noticing but not being caught up in rising cognitions
- developing cognitive fluidity – taking habits from one space and using in another (e.g. using metaphors: thoughts as passing cars; thoughts as clouds; hare brain, tortoise mind)
- paying attention to a wider range of the available percept or experiences.

The pay-off in terms of well-being is high. Mindfulness has the potential to lead to a reconstructed, more complex identity, in which self and thought are separated. Development of a watching self gives a different means of responding to (i.e. framing) and working on (i.e. self-managing) experiences of mental illness. Developing habits of greater occupation of the available attention reduces rumination and increases being in the moment – the flow concept we discussed earlier[444]:

> by increasing the amount of time a person spends thinking grateful and calming thoughts, there is simply less time to think upsetting and 'unhelpful' thoughts. Assuming that attention is a zero-sum game, the most efficient way to reduce negative and increase positive thoughts and emotions may be to focus on increasing the positive.

> (p. 28)

Overall, the personal qualities cultivated through mindfulness practice are nonjudging, nonstriving, acceptance, patience, trust, openness, letting go, gentleness, generosity, empathy, gratitude and lovingkindness[445] – qualities which are highly relevant to the personal recovery journey of people with mental illness.

Narrative psychology

A further clinical approach emerges from a sub-discipline called *narrative psychology*, which investigates the value of translating emotional experiences into words. This brings together insights from three strands of research[446]:

1. Inhibition – not talking about emotional trauma is unhealthy
2. Cognitive – development of a self-narrative allows closure
3. Social dynamics – keeping a secret detaches one from society.

One approach involves asking people to write about (or in other ways generate an account of) their experiences, as a means of making sense of their own story. The most beneficial story content includes placing the story in a context appropriate to its purpose, the transformation of a bad experience into a good outcome, and the imposition of a coherent structure[447]. Developing stories about growth, dealing with difficult life events and personal redemption

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Box 14.1 Weekly exercises for group positive psychotherapy

Week 1. Using your strengths
Use the Values in Action Inventory of Strengths[a] to assess your top five strengths, and think of ways to use those strengths more in your everyday life.

Week 2. Three good things/blessings
Every evening write down three good things that happened that day, and why you think they happened.

Week 3. Obituary/biography
Imagine that you have passed away after living a fruitful and satisfying life. What would you want your obituary to say? Write a 1–2-page essay summarising what you would most like to be remembered for.

Week 4. Gratitude visit
Think of someone to whom you are very grateful, but whom you have never properly thanked. Compose a letter to them describing your gratitude, and read it to the person by phone or in person.

Week 5. Active/constructive responding
An active/constructive response is one where you react in a visibly positive and enthusiastic way to good news from someone else. At least once a day, respond actively and construct-ively to someone you know.

Week 6. Savouring
Once a day, take the time to enjoy something that you usually hurry through (such as eating a meal, taking a shower, walking to class). When it's over, write down what you did, how you did it differently, and how it felt compared to when you rush through it.

Note:
[a]Peterson C, Seligman M. *Character Strengths and Virtues*. New York: Oxford University Press; 2004.

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all contribute to a positive narrative identity[448]. Empirical evidence suggests that this approach is particularly beneficial for groups who, as a whole, are not as open about their emotions: men[449], people with high hostility[450] and people with alexithymia[451].

Positive psychotherapy

An approach which brings together several of these methods is positive psychotherapy (PPT)[452]. The focus in PPT is on increasing positive emotion, engagement and meaning. For example, groups for depression undertake a series of weekly exercises, shown in Box 14.1.

These exercises are intended to tap into Seligman's proposed components of Authentic Happiness[407]. Randomised controlled trials of group PPT with mild to moderately depressed students ($n=40$) and individual PPT with severely depressed mental health clients ($n=46$) both showed gains in symptom reduction and happiness, with moderate to large effect sizes and improvement sustained at one-year follow-up[452].

We have described how some findings from positive psychology can be applied to work with people with mental illness. This requires knowledge and skills in the mental health workforce which are not, in general, currently present. So we turn now to current mental health practice, and how the processes of assessment, goal-planning and treatment for mental illness can support recovery.

The foundations of a recovery-focussed mental health service

What is the primary purpose of mental health services? In Chapter 2 we identified the many problems arising from a belief that the aim of mental health services is to treat mental illness. We argued that the primary purpose should be to promote personal recovery, and provided five rationales for this view in Chapters 4 to 8.

If the primary goal of mental health services is to promote personal recovery, then what does this mean for clinical processes? How do we recognise a recovery focus in a mental health service? How can the effectiveness of such a service be evaluated? In the next eight chapters we explore these questions. Our focus is on the day-to-day values, processes and work of mental health professionals.

Recovery starts with discomfort. For the consumer, this discomfort may involve experiencing the tension between professional expertise and lived experience. What fits? What doesn't? It is not enough to be passively compliant with treatment recommendations – active work is needed. For the professional, the journey towards working in a way which supports recovery also involves discomfort, at the level of values. A recovery-focussed professional has a fundamental orientation towards supporting the process of recovery in the consumer. It is fundamental in the sense of emerging from core values and informing every aspect of practice. Working in a recovery-focussed way therefore starts with a consideration of values.

Values

Whether or not explicitly stated, values underpin all behaviours by clinicians. Assessment asks about some topics and not others. Goal-planning prioritises what matters. Any intervention, including a decision not to intervene, has embedded values and creates ethical dilemmas. Reducing risk involves taking away choices. Protecting the public means segregating people with mental illnesses. Increasing effectiveness by tailoring services to local needs reduces equity of service provision. Respecting confidentiality means not being fully open with family carers. Clinical actions always involve placing a greater weight on one value than on another.

A consistent theme in services which have developed expertise in relation to recovery is that values are both explicitly identified and used to inform daily decision-making. This contrasts with the technical rationality described in Chapter 4, in which nomothetic evidence is intended to underpin clinical decision-making. This is what is meant by the call for ethics before technology[26]. To make this change requires three processes: making values explicit, embedding them in daily practice, and tailoring practice using performance feedback.

The first process is to **make values explicit**, and hence amenable to debate. This involves identifying and making visible the permeating organisational values in a live, rather than paper-based, way. This is different from the traditional organisational mission statement

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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

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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