

6 Recovery: the concept



The concept of recovery was conceived by, and for, people with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnoses.

The recovery movement began in the 1970s primarily as a civil rights movement aimed at restoring the human rights and full community inclusion of people with mental health issues.

Recovery approaches are viewed by the consumer movement as an alternative to the medical model with its emphasis on pathology, deficits and dependency. There is no single description or definition of recovery, because recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination.

Some characteristics of recovery commonly cited are that it is:

- a unique and personal journey
- a normal human process
- an ongoing experience and not the same as an end point or cure
- a journey rarely taken alone
- nonlinear—frequently interspersed with achievements and setbacks.

Recovery is a struggle for many people. The struggle might stem from severity of symptoms, side effects of medication, current or past trauma and pain, difficult socioeconomic circumstances, or the experience of using mental health services. Practitioners can also struggle as a result of the constraints of their work environment or when they sense a person's despair (Davidson & Roe 2007).

Personal recovery is defined within this framework as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.

Recovery approaches are different depending upon where a person is on their recovery journey. During an acute phase of illness, the person's capacity may be impaired to the extent that alleviation of distress and the burden of symptoms, as well as safety, is the primary focus of treatment and care. Regaining capacity for self-determination or deeper engagement should be a focus in the next stage of treatment and support. At later stages, when capacity is improved, there are opportunities for the person to consider broader recovery strategies.

The concept of recovery is represented in Figure 3 on the following page.



Figure 3: The concept of recovery



Recovery as an everyday human experience

Glover (2012) views people in recovery as 'living, loving, working and playing in their community' or in other words, doing the things that people need or wish to do or enjoy doing every day. The Mental Health Coordinating Council explains a benefit of this understanding of recovery:

Viewing recovery as a normal human process 'demystifies' the process of recovery from mental health problems and puts people in a better position to support someone in their recovery journey (MHCC 2008, p.14).

Recovery and relationships

Recovery is a personal journey, but it is rarely undertaken alone. For this reason, many commentators with lived experience of mental illness emphasise the theme of relationships with family, friends, peers and practitioners.

[It was] important for people in recovery to feel as if they are supported and cared for and identify 'being there' and available as a factor within friendships that seemed to help people in recovery. For professionals or caregivers, to go the extra step, to take a risk, to reach out and make a connection and 'be there' was important (Brown & Kandirikirira 2007, pp. 75–79).

Boydell et al. (2002) take up the theme of the importance of peers and refer to an enhanced level of understanding, support and acceptance that peers bring to one another by sharing their personal experiences of living with and overcoming mental health issues. This mutuality emphasises the role of peers in alleviating alienation and loneliness.

People with lived experience also discuss the importance to recovery of their parenting roles. A person detained in a forensic facility explained:

I remember my children coming to visit me in the hospital and at the time I was considered a danger to my children and myself. My children wanted to go outside on the grass to play, and luckily there was enough staff on duty for me to go out with them. Then my daughter fell down a manhole in the hospital grounds and she needed stitches in her leg. The hospital was very quick and helpful at arranging for me to be accompanied to the A&E with my daughter. She wanted her mum with her at a time of great distress and this was allowed to happen. This helped me in my self-esteem around being a parent and was very important in aiding my recovery and bond to my children (E.H. in Roberts et al. 2008, p. 178).



Recovery, culture and Aboriginal and Torres Strait Islander people



'Guthlan' Carolyn Fyfe discusses her journey of recovery and healing.

The art is called the 'Journey' ...

The journey of recovery and healing starts from the outer circle identifying the challenges that a person would experience. The colours:

Brown—the challenges to make the change in your thoughts/emotions (trying to move ahead)

Black are the dark times (depression)

Mauve—identified the reasons and have moved forward

White—you have the control

As you get closer to the centre it represents the wellness of health—socially, emotionally and spiritually.

It is a long journey and you need to have people who can let you explain your story and they theirs.

The second painting also by 'Guthlan' Carolyn Fyfe depicts the journey of layers that have impacted the social and emotional wellbeing of Indigenous people from invasion, colonisation and segregation to assimilation. As the layers and their impacts are removed a person's journey of healing and recovery starts.



Fyfe explains:

I never really had a name for this piece of art. I painted it to help educate others on the impacts of invasion, colonisation, segregation to assimilation and how this journey has affected the wellbeing of our Indigenous race socially, emotionally, culturally and spiritually—mind, body and soul.

Recovery and diversity

People's experience of recovery will be influenced by:

- their cultural identity—how they see self, kinship and relations with the broader community
- their explanatory models of illness, distress and wellness
- their experiences of torture, trauma, displacement, loss, racism and discrimination
- their spirituality.

The research tells of the serious and compounding emotional problems experienced by people with mental health issues emerging from discrimination on account of ethnicity, race, culture or sexual orientation. For some, the concealment of important aspects of oneself reflects a desperate attempt to survive, the need to 'pass' in an attempt to fit in. Gene Deegan describes how he tried to hide his mental health issues.

I'd internalized the old stereotypes about mental illness ... I feared losing my identity, hopes and dreams. I hid them at all costs. Deep down I stigmatized myself (Deegan, G 2003, p. 369).

Accounts tell of how hiding personal identity places a heavy burden on an individual and can impede recovery.

Recovery as living well

Commentators and researchers with lived experience also emphasise living well irrespective of any limitations arising from mental illness.

... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony 1993).

Glover (2012) describes recovery as self-righting – a natural process that people undertake, usually unconsciously, in response to difficulties and distress that interrupt the status quo of daily life.

Self-defined and not the same as cure

Pat Deegan, a psychologist who is in recovery with schizophrenia, reflects on the ongoing nature of her recovery.

Recovery is not the same thing as being cured. Recovery is a process not an end point or a destination. Recovery is an attitude, a way of approaching the day and facing the challenges. Being in recovery means recognising limitations in order to see the limitless possibilities. Recovery means being in control. Recovery is the urge, the wrestle, and the resurrection ...



My journey of recovery is still ongoing. I still struggle with symptoms, grieve the losses I have sustained ... I am also involved in self-help and mutual support and still use professional services including medications, psychotherapy, and hospitals. However, I do not just take medications or go to the hospital. I have learned to use medications and to use the hospital. This is the active stance that is the hallmark of the recovery process (Deegan, P 1996, p. 91).

A nonlinear process

Pat Deegan also discusses the nonlinear nature of recovery and how recovery is frequently interspersed with both achievement and setbacks.

Recovery is not a linear process marked by successive accomplishments. The recovery process is more accurately described as a series of small beginnings and very small steps.

Professionals cannot manufacture the spirit of recovery and give it to consumers. Recovery cannot be forced or willed. However, environments can be created in which the recovery process can be nurtured like a tender and precious seedling. To recover, psychiatrically disabled persons must be willing to try and fail, and try again (Deegan, P 1988, p. 11).

This brief discussion of the different perspectives of writers and researchers with lived experience of mental health issues reflects the importance of understanding and acknowledging that recovery will mean different things for different people.

Conceptual models of recovery processes

In recent years, mental health services and programs throughout Australia have adopted different models for helping staff to understand personal recovery processes and how they might enable and support personal recovery. While this new national framework is not seeking to standardise the use of particular models, the following models are highlighted as useful examples.

Andresen, Oades and Caputi (2003, 2006 and 2011)

By studying personal accounts of recovery, this Australian team of researchers developed a conceptual model of recovery processes to guide research and training and to inform clinical practices. The team identified four processes involved with personal recovery.

- **Finding and maintaining hope**—believing in oneself; having a sense of personal agency; optimistic about the future
- **Re-establishing a positive identity**—incorporates mental health issues or mental illness but retains a positive sense of self
- **Building a meaningful life**—making sense of illness or emotional distress; finding a meaning in life beyond illness; engaged in life
- **Taking responsibility and control**—feeling in control of illness and distress and in control of life.

Glover (2012)

Glover's model reflects the efforts that people undertake in their personal recovery journeys through a set of five processes.



- **From passive to active sense of self**—moving from the passive space of being a recipient of services to reclaiming one’s strengths, attributes and abilities to restore recovery
- **From hopelessness and despair to hope**—moving from a space of hopelessness and despair to one of hope
- **From others’ control to personal control and responsibility**—moving from others taking responsibility for recovery to the person taking, holding and retaining responsibility
- **From alienation to discovery**—‘finding meaning and purpose in the journey, doing more of what works and less of what does not work; learning from past experiences and incorporating that lesson into the present; acknowledging that journeys always have something to teach us and contribute to our sense of discovery’
- **From disconnectedness to connectedness**—moving from an identity of illness or disability to an appreciation of personal roles and responsibilities and to ‘participating in life as a full citizen and not through the powerlessness of illness’.

As with the model developed by Andresen, Oades and Caputi, this personal recovery effort model emphasises personal responsibility and personal control.

This is a challenging concept for workers in helping and caring professions. Their impulse is to ‘do for another’ who is experiencing distress, pain, illness or disability. However, constantly ‘doing for another’ can contribute to a state of impotence and inability. A recovery approach encourages people to take an active role and reclaim responsibility for the direction of their life (Glover 2012).

Le Boutillier, Leamy, Bird, Davidson, Williams and Slade (2011)

This study analysed 30 international documents to identify the key characteristics of recovery-oriented practice guidance. The researchers developed an overarching conceptual framework to aid the translation of recovery guidance into practice. The five practice domains and 17 competencies of recovery-oriented practice developed for Australia’s national framework are consistent with the themes and categories of recovery identified by these researchers.

In terms of people’s recovery processes, this research team identified similar but differently worded processes to those proposed by Andresen, Oades and Caputi and by Glover.

The interconnectedness of personal recovery and clinical recovery

A growing number of commentators (including researchers with personal experience of mental illness), while acknowledging the difference between clinical recovery and personal recovery, argue that the two types of recovery are complementary and support one another (Glover 2012; Slade 2009a).

A recent study conducted by researchers with lived experience explored the views of people with psychosis about the relationship between clinical recovery and personal recovery. The research team reports:

All participants highlighted symptom change as an indicator of their recovery, and change in symptoms was often accompanied by alleviation of distress and personal change.

Improvements in psychotic symptoms may be important to recovery, but only in conjunction with a range of other factors. Furthermore, the findings in relation to the need for change within symptoms may indicate that although full symptom alleviation or removal may be important for some service users, for others, changes in the nature of the symptoms may be just as important. For example, recovery may mean the continued presence of symptoms but without their negative impact (Wood et al. 2010, pp. 468–469).



There is general agreement in the research that while recovery is much broader than symptom improvement, alleviation of distress associated with symptoms and assistance to manage the illness make an important contribution (Slade 2009a). There is also agreement that an increased sense of wellbeing regardless of continuing symptoms can contribute to a reduction in those symptoms or in their severity (Davidson et al. 2006). Increasingly the importance of physical health, activity, fitness, exercise, healthy diets and healthy lifestyles are being emphasised. Physical fitness through increased activity and exercise contribute to recovery by increasing stress tolerance, promoting resiliency and strengthening a person's sense of wellbeing and self-mastery.

The major implication for practice and service delivery arising from the complementary nature of clinical recovery and personal recovery is the need for practitioners and services to offer their assistance and expertise through the medium of a collaborative working alliance with each person and where appropriate, their family (Oades et al. 2005). Another principle is the mutual sharing of lived and trained expertise in crafting a service plan.

Key practice tasks emerging from the interconnectedness of clinical and personal recovery include: fostering personal responsibility, promoting shared decision making, supporting the development of motivation, self-management and self-empowerment, and being responsive to families.

Recovery, self-determination and safety

Recognising that consumers' self-determination is a vital part of successful treatment and recovery, the principles of recovery emphasise choice and self-determination within medico-legal requirements and duty of care. Striking a balance requires an understanding of the complex and sometimes discriminatory nature of the goal of reducing all harmful risks (Slade 2009a, pp. 176–179). Services must manage various tensions including:

- maximising choice
- supporting positive risk-taking
- the dignity of risk
- medico-legal requirements
- duty of care
- promoting safety.

Maximising people's self-determination requires continued efforts to reduce coercion, seclusion and restraint.

Australia's National Mental Health Seclusion and Restraint Project (NMHSRP) 2007–09 promoted discussion and action to reduce seclusion and restraint. The 11 Beacon demonstration sites established as part of the project demonstrated that simple changes can lead to major improvements. The following strategies were identified as influencing positive outcomes to reduce seclusion: leadership to effect organisational change, the use of data to inform practice, investment in workforce development and debriefing techniques involving people with a lived experience, their carers and staff.

Australian state and territory governments as well as professional associations embraced the objectives of the NMHSRP and reviewed their policies and practices.

There is a detailed discussion of recovery, self-determination and safety in *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*.

