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Recovery-orientation in Mental Health Services

Section A: Recovery in mental health services: A review of the literature

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Summary of the MRP portfolio

This portfolio investigates personal recovery-orientation in mental health services in the U.K. **Section A** provides a review of the literature on personal recovery and recovery-orientation and goes on to critically examine how personal recovery has been introduced into services from a social positioning theoretical perspective. The review highlights the need for research on the process of introducing the concept of recovery and recovery-oriented practices into services.

Section B describes a study carried out in a recovery team in a London borough at the early stages of introducing recovery-oriented practices. The paper gives a background and rationale for the study, describes the focus groups of service users and staff and how they were analysed using Foucauldian Discourse Analysis. Recovery was constructed as both medical (clinical) and personal recovery by staff, positioning service users differently depending on the wider discourses drawn upon. This had the effect of opening up or closing down opportunities for personal recovery. A personal recovery discourse did not seem to be available to service users. Looking closely at taken-for-granted discourse in the service could help to alert staff and service users to how available ways of talking can shape their understandings and impact opportunities for action for service users and staff.

Section C provides a critical appraisal of the study and the researcher's reflections on the process, paying attention to the research skills he developed, what he would do differently if the project could be done again, how the research will impact on his clinical practice and what further research he would like to carry out and how he would go about this.

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Recovery in mental health services: A review of the literature

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Abstract

This paper provides a review of the literature on recovery and the move to recovery-oriented care in mental health services. It outlines the historical context in which people with mental health problems have been positioned within services. The concept of recovery is discussed and some of the problems with its definition are explored. The policy frameworks within which recovery has been and is being introduced to mental health services is then reviewed and the 'recovery journeys' of services and the complexities of putting personal recovery at the heart of services are examined. The challenges for services and staff are explored and some theoretical consideration is given to these challenges. The available empirical literature on the move to recovery-oriented practice is then critically reviewed and gaps in the research are identified. Results suggest that we are just at the beginning of the journey toward putting personal recovery at the heart of service provision. Up to now most research has been on the development of a conceptual understanding of personal recovery and been qualitative in nature. The change in the relationship between service users and staff seems central to successful support of personal recovery by services and the process of change to recovery-orientation needs to be better understood. Finally the future of recovery research and its particular challenges are considered along with the potential value of research taking a social positioning and discursive perspective in this area.

Structure of the Review

An influential definition of personal recovery has come from Bill Anthony (1993), who described recovery as:

“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 with limitations caused by mental illness”

This paper will review the literature on recovery, in particular personal recovery, and the move to ‘recovery-oriented’ practice in mental health services with a focus on how service users have been ‘positioned’ in services historically and currently. It will systematically review the associated conceptual and empirical research drawing on social positioning theory (Harré & Moghaddam, 2003) to explore how the concept of recovery has and is being introduced in mental health services. Gaps in the literature and some of the difficulties encountered along the ‘recovery journey’ of services will be identified and future research directions will be discussed.

Historical Context: From the Asylum to Community Care

The move in Western societies from the construction of people with mental health problems as ‘mad’, having knowledge that others did not and living alongside people in their communities to ‘having a mental illness’ which needed to be treated by doctors and segregated in asylums seems to have happened at the end of the 18th century (Foucault, 1988). Since then, and with the advancement of science, there has been a dominant tendency for people with mental health problems to be subjected to medical treatments

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(medication, electro-convulsive therapy and other physical treatments) in an effort to cure their illnesses in the same way that a physical illness would be treated, by altering a disease process seen as located in the brain. The very recent move from institutionalized care in psychiatric hospitals to caring for people with mental health problems in the community began in the 1960's in the U.K. It was made possible by a change in attitude toward the ethically and morally questionable segregation of 'mental patients' from society, the advance in efficacy in psychotropic medication for the 'management' of people with mental health problems (though this is debated) and a political impetus to close expensive psychiatric hospitals (Newnes, Holmes & Dunn, 1999). Some of the values driving the move to care in the community fit well with the ethos of a more social model of mental illness (Beresford, 2002). 'Patients' would be integrated, contributing members of their communities and be able to draw on the social capital of its members and in theory this would benefit their mental health. However, whether it is because the resources and supports necessary to meaningfully include people with mental health problems were not sufficiently put in place or because the prevailing negative attitudes and stigma toward this group had not been fully considered, many believe that service users are in many ways still 'institutionalised in the community' (Carr, 2008).

Alongside the move to community care, there has been a change in how we conceptualise the longer term outcomes for people with serious mental illnesses. The Kraepelinian view of 'chronic schizophrenics' was challenged by longitudinal studies over thirty years which showed that people diagnosed with schizophrenia showed recovery (defined as becoming symptom free) rates of between 49 and 68% (Harding et al., 1987 a and b). These results were significant and ran contrary to the perception of serious mental

illness being a life-long condition and untreatable. The notion of recovery has undergone many changes in meaning, but is now widespread both in the rhetoric and discourses of people who use services and services themselves, as I shall now discuss.

Recovery: a nebulous concept

Although there seems to be a consensus that recovery is an important concept for service users and mental health services, as exemplified by a recent recovery-themed issue of the *International Review of Psychiatry* (2012) and the *Journal of Mental Health* (2012), there remains a lot of confusion around its definition, who it is for and what it looks like in practice for people who use services and for services themselves (Farkas, 2007; Slade, Amering & Oades, 2008). Slade (2009) helpfully separates 'clinical' recovery, which can be seen as recovery 'from' mental illness - the alleviation of symptoms and a return to 'pre-morbid' functioning, from 'personal' recovery where being 'in recovery' means living a meaningful life even if mental health problems persist (Anthony, 1993).

Clinical recovery encompasses how we traditionally think about 'cure' and locates understanding within a medical frame and developed from the academic and predominantly medical mental health literature. Recovery from the illness is operationalised by sustained remission of symptoms, a return to 'normal' functioning and is the same for everyone (Lieberman & Kopelowicz, 2002).

The focus of the present review is on personal recovery, which emerged from the service user movement in the United States in the 1980s, the personal experiences and narratives of pioneers such as Pat Deegan (1988, 1996) and the field of psychiatric

rehabilitation (Ralph & Corrigan, 2005). Personal recovery is a process which is unique to each individual and is often referred to as a personal recovery journey (Anthony, 1993; Deegan, 1988). The journey has forward and backward momentum and a stage conceptualization has been proposed (Andresen, Oades & Kaputi, 2003; Prochaska & DiClemente, 1983).

The individual and subjective nature of the recovery journey makes the concept difficult to operationalise and thus measure, although much work has been done to develop standardized measurement tools that track both personal recovery and the recovery-oriented nature of mental health services (Campbell-Orde, Chamberlain, Carpenter, & Ledd, 2005; Williams, 2012). Also a recent large scale systematic review and narrative synthesis produced a conceptualization of personal recovery (Leamy et al., 2011). The aim was to synthesise published literature and to produce a model of personal recovery within an empirically-based conceptual framework. Thirteen characteristics of the personal recovery journey were elicited along with five recovery processes; connectedness, hope and optimism about the future, identity, meaning in life and empowerment. The authors also found that their description of change mapped onto to the transtheoretical model of change (Prochaska & DiClemente, 1983). Consistent with this, Repper and Perkins (2003, 2012) reviewed people's recovery journeys and identified three key factors: hope (including a sense of personal agency), control (taking back control of one's destiny) and opportunity (the chance to do things you value).

In the current literature there is little overlap between the constructions of personal and clinical recovery. In fact there seems to be a battle both politically and professionally regarding how recovery is constructed, with polarised positions (Beresford, 2002). It may

be important for these positions to become more integrated in order for recovery-oriented practices to sit more comfortably in services.

Recovery in Policy

The National Service Framework for Mental Health (DOH, 1999) set the basis for recovery-oriented service delivery in the U.K. with its emphasis on partnership, empowerment and community-based care. Since then policy initiatives have called for recovery-oriented practice to be the guiding light for mental health services in the UK (DOH, 2007, 2009, 2011), thus re-orienting services to support the personal recovery of service users. A joint position paper between the Care Services Improvement Partnership (CSIP), The Royal College of Psychiatrists and Social Care Institute for Excellence (SCIE) provided guidance on planning, development and delivery of recovery services (Care Services Improvement Partnership, 2007). The New Ways of Working document (DOH, 2009) recommended that clinical psychologists should work to support personal recovery by working collaboratively with service users and other professionals in the mental health team. Service users have also called for more talking therapies to be available as an alternative to medication.

Recovery-orientation was previously adopted as the overarching model of care for mental health services by the U.S. Surgeon General in 1999. Since then, the goal of recovery-oriented practice has been adopted, at least at a theoretical level across the world (Anthony 1993; Slade, Amering & Oades, 2008). However, the change from the traditional disease model, and the values and practices of services informed by it, has been problematic. There are many reasons for this including the difficulty of embracing change

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from a professional-led, illness- and symptom-centred care to a client-centred, strengths-based empowerment model (Future Vision Coalition, 2009; Shrank & Slade, 2007).

Recovery in Practice – The U.K. Context

“What service users want is not expensive: it is to be heard and valued, understood and respected and supported to attain their aims.” (Carr, 2008)

Perkins and Slade (2012) described recent efforts to introduce recovery to mental health services in the English context and reported a disjunction between policy and practice. Davidson et al. (2009a) suggested that the transformations required to fully implement the recovery agenda are profound and the manner in which we hope to support service users requires a major re-thinking of how we work as mental health practitioners. O’ Hagan (2004) stated that recovery-oriented practice should put service users at the heart of their care, give them real choice around the services they receive and employ them as peer support workers and at all levels of the organization. Clinical psychologists can work in a recovery-oriented way by using individualised formulations over diagnosis, using therapy to promote personal meaning and responsibility and to support the development of self-management skills (Slade, 2009). Some work has been done around how services can become more recovery-oriented but implementation of these recommendations has been patchy.

Le Boutellier et al. (2011) highlighted the complexity of translating the principles of personal recovery into practice in the mental health services. They developed a conceptual

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framework from existing international guidelines around recovery-orientation in services. The framework consisted of 16 themes grouped into four practice domains; promoting citizenship, organizational commitment, supporting personally defined recovery, and the working relationship.

Shepard, Boardman and Slade (2008) in their policy paper from the Sainsbury Centre for Mental Health, pointed out that 'Making Recovery a Reality' would require huge organizational transformation, including changes in power relationships between staff and service users. They identified obstacles to implementing this change and outlined ways that transformation might happen, including a change in recruitment practices so that many more service users are employed by services and the use of repeated auditing of services against practice standards. They suggested one methodology for this organizational change, adopting a systems approach across three stages. The paper also highlighted key organizational challenges for the adoption of recovery-oriented practice including delivering comprehensive user-led education and training programmes, establishing a recovery education centre to drive programmes forward, ensuring organizational commitment and creating a 'culture' of recovery. They also emphasised increasing personalization and choice, changing the way we approach risk, redefining service user involvement, transforming the workforce, supporting staff in their recovery journey, and increasing opportunities for building a life 'beyond illness'. Implementing Recovery – Organisational Change (ImROC; 2011) is a partnership project between the NHS Confederation, the Centre for Mental Health (formerly the Sainsbury Centre) and the National Mental Health Development Unit. The project is a multi-site study initiative using the methodology outlined above to create a pro-recovery organisational climate.

Challenges for Services and Staff

The changes highlighted above are profound, and have brought many challenges for services and staff both at a systemic and individual level. At the systemic level, Piat, Sabetti and Bloom (2010) argued that change to a recovery-orientation requires an active leadership from decision makers in order to push through change. Slade (2012) suggested that a move towards supporting recovery involves a re-organisation of power arrangements. However, the current NHS climate of uncertainty and cuts is likely to make any major change process which requires shifting power away from professionals very difficult. Its attraction may lie in the possibility of saving money by employing more non-professional staff or discharging people from services sooner.

At the individual level Davidson et al. (2006, 2009a) highlighted concerns that mental health services and staff have about the changes associated with moving to working in a recovery-oriented way. These included the belief that recovery was not new and that they were already working in a recovery-oriented way. They also highlighted the definitional difficulty mentioned earlier; staff could not conceive of service users as being in recovery when they remained symptomatic and they believed that creating hope of recovery was irresponsible and beyond the reach of some service users. There was also a concern that recovery practices which include allowing service users to set their own goals opened the service to liability when those goals require positive risks to be taken.

One of the fundamental changes that staff find difficult concerns the nature of the relationship between service users and staff (Borg & Kristiansen 2004). Roles need to be re-negotiated, and changes in practices and service structures are required. Borg &

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Kristiansen (2004) found that the staff that service users found most helpful were those who could deal with the complexities of the change process, conveyed hope, shared power and were available when needed. Recent Department of Health guidance (DOH, 1999) specified that in pre-qualification training staff should develop values and practices that are congruent with recovery values. Similar guidelines can be found in the British Psychological Society accreditation document for Clinical Psychologists (BPS, 2010). Hicks, Dean and Crowe (2012) suggest that staff move toward developing supportive working alliances with service users, while Hobbs and Baker (2102) highlight the importance of being able to instil hope.

Oades, Crowe & Nguyen (2009) developed the Collaborative Recovery Model (CRM) (Oades et al., 2005) which enabled staff and service users to implement a person-centred, strengths-based coaching framework. The CRM focuses on service user strengths and values, with an emphasis on the alliance between staff and service user, focusing on goals and the potential for growth in the service user and also staff members.

It is important to acknowledge, however, that many social and historical barriers to working in true partnership exist (Holtum et al., 2011). In the next section I will outline some of the theoretical literature that addresses how service users' positioning in services has changed and how we might use this to think about the introduction of recovery-oriented ways of working.

Theoretical Perspectives - Social Positioning of Service Users

“The study of local moral orders as ever shifting patterns of mutual and contestable rights and obligations of speaking and acting has come to be called positioning theory” (Harré & van Langenhove, 1999).

According to this theoretical perspective a ‘position’ is a combination of assumed personal attributes which impinge on the possibilities that are open to a particular person. A ‘position’ exists as a pattern of beliefs in the members of a group or community and is social in the sense that one member’s belief is similar to that of another (Harré & Moghaddam, 2003). This position is maintained interpersonally based on the combination of assumed attributes, e.g. a person who is positioned as powerful by a group. That person is given most right to speak and his or her words are respected. Positions are relational in that if one person is positioned as power ‘ful’, another is comparatively power ‘less’ (Harré & van Langenhove, 1999).

Madness and Civilization (Foucault, 1988) is a study of the construction of ‘madness’ in western society through the ages. In the Classical period people who were labelled mad were shut away from the world along with other ‘social deviants’. As time progressed the conception of madness as melancholia/mania and hysteria/hypochondria were located in medical circles and they were eventually seen as mental diseases. Doctors began to treat people with mental health problems by trying to find a cure for their disease and people with mental health problems became patients. There have been huge advances in how society and services view and treat people with mental health problems culminating in the move to caring for people in their communities and the professional ideal of treating them

as equal citizens. The service user movement has become very influential and has been at the forefront of the involvement of service users in the development of mental health services (O' Hagan, 2004). However, much stigma and discrimination remains both within and outside of services (Corrigan, 2004). There has also been a change in how services interact with service users to the point where service users are now routinely employed alongside professional staff in some of the more recovery-oriented services (Perkins & Slade, 2012).

These changes in how services care for and support service users can be viewed as mapping changes in how staff and service users have positioned themselves and have been positioned in terms of power and also in terms of how mental illness has been conceptualized. Recovery-oriented practice calls for service users to be at the heart of decision making about their care and positions services as being 'on tap, not on top' (Shepard, Boardman & Slade, 2008). This radical shift in where power is located in the relationship between staff and service users is understandably difficult for services to take on board, as with any major change in organizational policy and negotiation of long-standing roles and responsibilities (Davidson et al., 2009a).

The shift to viewing the role of mental health services as helping people to achieve personal recovery means focusing less on the idea of 'cure' and clinical recovery, and staff 'doing things' to service users to 'make them better'. However, services are heavily invested and trained in thinking about mental illness in the same way as physical illness (e.g. National Alliance for Mental Illness). This disease model of understanding mental illness as being primarily biological in origin, with social and environmental explanations acting as

'triggers' or secondary to the disease process is widespread in our discourse and maintains the social positioning of service users as passive patients (Harré & van Langenhove, 1999). There is actually very little evidence supporting the utility of this way of thinking about mental illness (Moncrieff, 2007), and in fact Angemeyer et al. (2011) reviewed research on the utility of this view and found it can actually *increase* stigma. Psychiatry focuses on symptoms and disorders and focuses entirely on 'treating' them, positioning people with mental health problems as ill and disempowered (Masterson & Owen, 2008). The recovery model emphasizes a shift from a medical understanding to understanding based on personal experience. Boyle (2011) explained that there is an accepted and unquestioned discourse around 'symptoms' and 'disorders' which pushes people's experiences and their meanings into the background and gives them a secondary role in explaining how they feel. Masterson and Owen (2006), in a study of empowerment, argued that the success of the recovery model depends on the acceptance of a recovery discourse as a successor to the dominant discourse of medico-psychiatry. In *The Birth of the Clinic* (1963) Foucault described the medical gaze; the dehumanising way that the 'person' is medically separated from the body and how this process, not necessarily consciously, allows the professional to separate from the disturbing individual. Arguably, clinical psychology also maintains this discourse by focusing on individualised pathology and working primarily at the intrapsychic level, keeping the person's social context on the periphery of explanation. However, the contexts most often associated with mental distress are social circumstances such as child abuse, poverty, domestic violence, sexual abuse and racism (Boyle, 2011). These things involve relatively powerful groups (governments, corporations, majority white

people) damaging less powerful groups. Context is therefore linked to the operation of power.

Foucault argues that 'truths' do not emerge naturally but are constructed to privilege certain groups. He describes a 'field' as a particular space in society that gets used in a particular way (Danaher, Shirato & Webb, 2000). Each field operates according to its own rules and procedures and assigns roles to the actors within the field. There are acceptable ways of behaving and talking according to the particular field you are in. If we think of a mental health service as a field, it could be hypothesized that service users assume a role and live by the rules and regulations of the service. They are allowed to behave and speak in a particular way. The service positions them in a particular role by the language and discourses it uses. Discourse is the way the field 'speaks of itself to itself' (Foucault, 1982) and has a major role in how the rules are maintained. Taken from this perspective, if personal recovery is to be at the heart of the mental health system we need to think about how to negotiate a huge change in the rules, procedures and discourses and be able to question 'taken-for-granted' notions that are constantly recycled through myriad small day-to-day social interactions, both formal and informal.

Relevant empirical research on recovery practice

The aim of this literature search was to review the evidence around the process of introducing a personal recovery-orientation into mental health services. This includes efficacy of services run by services users or where service users are meaningfully employed, and guidance and interventions that focus on recovery-orientation. A comprehensive literature search using the Psychinfo, Medline, Cambridge and the

Cochrane Database of Systematic Reviews databases from 1900 to present was conducted. Key search terms were recovery, recovery orient*, mental health service, change, service user (see Appendix 1). Reference lists of recent reviews were scanned and websites of service user and recovery groups were also searched. One systematic review, two randomised controlled trials, four intervention manuals and practice guideline documents, and two scholarly books were identified by the search and are described and critiqued below.

Systematic Reviews

Doughty and Tse (2005), in a systematic review of 26 empirical papers and two systematic reviews, looked at the effectiveness of service user-run mental health services internationally. Overall they found positive support for these services and positive outcomes including higher levels of satisfaction with services, general well-being and quality of life for service users. It should be noted that these services included those that used a more partnership-based model in which service users worked alongside clinical staff. Any interpretation needs to take this into account and a more stringent definition of user-led in terms of autonomy and self-governance would be useful to tease out. Future research should look at fully consumer-run services and compare them to the participatory approach included here.

Randomised Controlled Trials

Greenfield et al. (2008), in an RCT, compared the effectiveness of an unlocked, service user-run crisis residential programme with a state-run inpatient locked ward. In the U.S.A., 393 participants were randomly assigned to the two services and cost, level of functioning, psychiatric symptoms, self-esteem, enrichment, and service satisfaction were measured at baseline, at 30 days, six months and one year follow-up. Level of functioning was measured using the Uniform Client Data Inventory (UCDI) (Tessler & Goldman, 1992). The Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham 1962) measured psychiatric symptoms from the professional perspective and the Hopkins Symptom Checklist-40 (HSCL-40) (McNiel et al., 1989) assessed psychiatric symptoms from the service user perspective. Self-esteem was assessed using the Rosenberg Self-Esteem Scale (Rosenberg et al., 1989) and The Quality of Life Interview (QOLI) (Lehman, 1988, 1995) was also used. Service user satisfaction was measured using the Service Satisfaction Scale-Residential Form (SSS-RES) adapted from the SSS-30 (Greenfield & Attkisson, 1989). Participants in the service user run system improved significantly more on professional-rated and self-reported psychopathology than participants in the state-run condition. It was notable that service satisfaction was dramatically higher in the service user run system. Definitive cost analysis was difficult because those readmitted from the service user condition were normally readmitted to the state system. More research is needed comparing groups that have the opportunity to be readmitted to the service user run condition. There was a high attrition rate (30 and 43%) and so the follow up data need to be viewed cautiously. The sample again was at the more severe end of mental health problems. However it was very diverse

ethnically and results suggest that a more service user-centred model of crisis resolution could be an alternative to the traditional practice of inpatient units.

Barbic et al. (2009) conducted a randomized controlled trial of the effectiveness of a recovery-oriented intervention comparing a group of 16 service users with serious mental health problems under an assertive outreach programme who used a recovery workbook in a 12 week group format which aimed to increase awareness and education around of recovery with a group of 17 treatment as usual (TAU) service users. Perceived level of hope, empowerment, recovery, and quality of life were measured using the Herth Hope Index (Herth 1991), The Empowerment Scale (Rogers et al., 1997), The Recovery Assessment Scale (Corrigan et al., 2004), and The Quality of Life Index (Ferrans & Powers, 1985). The authors reported that service users who attended the groups showed increased levels of hope, personal recovery and empowerment compared to TAU. No follow-up data are provided. Participants who receive assertive outreach treatment are not typical of all people with mental health problems and so generalization should be cautious. People with alcohol and drug dependency were also excluded. However these results are hopeful and the inclusion of these groups as part of recovery-oriented services should be considered.

Intervention manuals and recovery-orientation guidance

Bird et al. (2011) developed an intervention aimed at increasing the focus of Community Mental Health Teams (CMHTs) on personal recovery. The intervention focused on two components; recovery-promoting relationships between staff and service users and working practices of staff. The intervention aimed to change the nature of relationships between staff and service users by targeting staff values and attitudes, and increasing the

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use of coaching skills, strengths assessments, personal values and service user preferences and goal setting. They provided training to staff in two CMHTs; one in London and one more rurally, which included training in 'coaching conversations' which involve a specific interpersonal style that staff can use with service users. Coaching is not therapy, but can help service users to discover their resourcefulness, build on strengths, and make changes based on their own values and goals. They have also produced materials and resources that services can use when implementing these strategies. A randomised controlled trial is underway to test the efficacy of the intervention and a pilot project has shown promising results.

Clarke et al. (2006) developed an individualized intervention called Collaborative Goal Technology (CGT) to help service users strive for personally meaningful goals and at the same time enhance recovery-oriented practice within services that use CGT by allowing staff and service users to collaboratively monitor personal and group goals. It draws on the Collaborative Recovery Model (Oades, et al., 2005) which emphasizes recovery values, collaboration and support of service user autonomy, while also recognising that staff need to 'recover' from old practices. Staff orient the service user to the concept and idea of recovery, develop time-framed goals together, prioritize those goals, negotiate progress indicators, review goal progress and ultimately attain a goal attainment index. To date there is good anecdotal evidence for the approach and a case study is presented. It will be important for the programme to be evaluated and research carried out to investigate if this tool leads to better recovery-oriented outcomes for service users and whether it can improve goal setting for services.

Sheppard, Boardman and Slade (2008) produced 10 top tips for recovery-oriented practice from the Sainsbury's Centre policy documents around the introduction of recovery to services. Slade (2009) produced a practical guide for services which aimed to support the development of a focus on recovery within services. Using an evidence-based personal recovery framework, and with an emphasis on the central importance of relationships and values, he produced 100 action points which mental health staff can use to support recovery. These documents are easily available and are a practical way for staff to move to recovery-oriented working. However they are not mandated requirements for service delivery. Future research should aim to have these practices included in NICE guidance.

Two scholarly books have been produced with a specific focus on recovery and recovery-oriented practice. Slade (2009) published 'Personal Recovery in Mental Illness' which is an excellent introduction to the recovery literature and also covers recovery-orientation. Davidson et al. (2009a) published a book entitled 'A Practical Guide to Recovery-Oriented Practice' which is a valuable resource for services and staff involved in the move to introducing recovery practices. However, practical guidance and books are often not widely read by all team members and evidence of their efficacy is needed.

Summary of Review and Future Research

There has not been a large amount of empirical research conducted on the introduction of recovery practices into mental health services. Up to now most research has focused on the development of a conceptual understanding of personal recovery. However, with the advancement of the validation of specific recovery measurement tools and the need to evaluate how recovery is being implemented in services the onus has shifted to trying to

quantify recovery and to assess the impact of a personal recovery framework on services. This review has brought together some of the existing research and this is summarised below along with a discussion of where future research might focus.

A systematic review found positive support for recovery-oriented services in terms of satisfaction with services, well-being and quality of life. Two randomised controlled trials also show promising results for both an intervention that provided recovery education and awareness and also for a service user-run service. An intervention manual which aims to train community mental health teams to become recovery-oriented has been developed and is currently being trialled, and Collaborative Goal Technology has been developed to collaboratively plan and manage service user goals. Specific practical guidance documents have been drawn up for services and staff on how to implement recovery in their services, and two books have been published with a specific recovery-orientation focus.

The future for research in recovery and recovery-orientation in services is complex. Davidson et al. (2009b) compared the relationship between evidence-based practice and recovery as like that of oil and water and/or oil and vinegar. Staff are trained to work in a 'medical model' approach that tends to be viewed as scientific even though it has been effectively criticised as based on little or no evidence (Bentall, 2003; Moncrief, 2007). The outcomes that are traditionally viewed as important are symptom remission, compliance with medication and reducing risk. At the same time as being required to be evidence-based (NICE, 2009) services are also being told to be recovery-oriented (Davidson et al., 2009b). This begs the question, 'are recovery based values and what is assumed to be

evidence-based practice compatible?' For example, the standard research trial approach of specifying an outcome before the trial is problematic when service users are not consulted and place different values on outcomes to those of researchers (Trivedi & Wykes, 2002). The move to recovery-oriented practice calls for the outcomes that are deemed important be broadened to those asked for by the service user, including community involvement and a meaningful life. Arguably clinical psychology should enable a more personalised and personal-development perspective, but it has tended to follow the medical diagnostic system, perhaps in order to have its services recognized and validated because diagnostic clustering is the dominant model for 'cost-effective' service commissioning and delivery.

Very little research exists on the process of introducing recovery-oriented practices to mental health services. Qualitative methodologies are well placed to look more closely at the types of conversations that are being had with staff after the introduction of recovery-oriented practices and also to track how the relationship between service users and staff changes with time. Longer term quantitative data that measure outcomes that are more relevant to personal recovery are needed. Recovery-oriented constructs such as empowerment, quality of life and community engagement should be routinely measured in services.

Conclusion

The present paper reviewed the empirical literature on the recent emphasis on the move to recovery-oriented practices in mental health services. The little evidence that exists suggests that service users and staff can potentially benefit from this change, but that the introduction of the concepts and the change in the involvement of service users needs to be

fully implemented. The relationship between service users and staff needs to change to one of partnership and alliance, and guidance exists to help staff with the change. According to positioning theory, in order for this change to occur, service users need to be socially positioned in services such that they assume a different set of personal attributes which will open up possibilities and knowledge for them; they should be given the right to speak and their words be respected. Staff should adjust existing patterns of beliefs about service users and re-negotiate their role and relationship with service users. These beliefs need to be widespread throughout the organisation and a discourse of personal recovery should be available to all. Whilst some possible mechanisms for the difficulties of change have been highlighted, to date there does not appear to be any research looking closely at the process of introducing the personal recovery-orientation into a mental health service. Therefore in-depth qualitative research may be helpful, and a discourse analysis approach could highlight the extent to which discourses and related practices are being challenged and where they appear more entrenched. Indeed, looking closely at taken-for-granted discourse in the service could help to alert staff and service users to the way available ways of talking can shape their understandings, and more importantly, their positionings.

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What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices? A Foucauldian Discourse Analysis

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Abstract

Background: Policy initiatives are calling for mental health services to change their ways of working to prioritising the promotion of service users' personal recovery. This requires a major re-negotiation of working practices and the relationship between service users and staff/services and their respective social positions. Preliminary research has shown that change has been problematic.

Aims: To explore the construction of recovery and the positioning of service users and staff during the adoption of recovery-oriented practices in a community support and recovery team.

Method: Transcripts of two rounds of focus groups with service users (n=9) and staff (n=5) held six months apart, service user care plans and Recovery Star notes were analysed using a Foucauldian Discourse Analysis.

Results: Recovery was constructed as clinical/medical and personal recovery, at different times and in tension with each other. These constructions positioned service users as dependent, passive and hopeless or empowered and hopeful, and staff as helpless or facilitative. It was also apparent that a discourse of personal recovery was not available to service users. Staff oscillated between the constructions of recovery as medical and personal resulting in different subject positions and opportunities for action.

Conclusion: Adopting a recovery-orientation in services should lead to service users being positioned as more influential in decisions about their treatment and modes of support from the service, and services less likely to dictate their treatment. However, this can only happen if the recovery-orientation constitutes a widely shared discourse with all its assumptions and associated practices. The problematic aspects of the medical discourse and how it can position people socially and how those positions impact on the potential for personal recovery needs to be highlighted.

Keywords: *recovery, recovery-orientation, services, discourses*

Introduction

The recovery approach in mental healthcare has been endorsed at the policy level across the English-speaking world (Slade, Amering & Oades, 2008). However the implementation of recovery values and practices at the service level is proving more problematic and is challenging, in different ways, for both mental healthcare staff and service users (Davidson et al., 2006; 2009). Not least among the challenges is the problem with how to define something which by its nature is individual and looks different for each person. One influential definition comes from Bill Anthony (1993), who described recovery as:

“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 with limitations caused by mental illness.”

This contrasts with ‘clinical’ recovery, the more traditional psychiatric definition of ‘recovery from’ mental illness which includes the alleviation of symptoms and a return to ‘pre-morbid’ functioning and is the same for everyone (Lieberman & Kopelowicz, 2002). Slade (2009) introduced the idea of ‘personal’ recovery to refer to being ‘in recovery’ as outlined by Anthony above, and includes living a meaningful life even if mental health problems persist. Another important aspect of recovery is that it is a process or journey, and not just an outcome, which has forward and backward momentum and happens in stages (Andresen, Oades & Kaputi, 2003; Prochaska & Di Clemente, 1983).

Historically the recovery movement was begun by ex service users in the United States in the 1980s. Pioneers such as Pat Deegan (1988) bravely told the narratives of their personal recovery journeys. Leamy et al. (2011), in a large scale systematic review and

narrative synthesis, produced a conceptualization of personal recovery with an empirically-based conceptual framework. This, along with the development of standardised measures (Campbell-Orde et al., 2005; Williams et al., in press) has helped to operationalise the nebulous concept of personal recovery and enabled a cross-stakeholder group understanding of recovery.

Policy initiatives have called for recovery-oriented practice to be the guiding light for mental health services in the UK (DOH, 2007, 2009, 2011a). This means that services should re-orient their practices to support the personal recovery of service users, placing their personally meaningful aims and goals central to service delivery. However, the change from the traditional disease model, and the values and practices of services informed by it, has been problematic (Davidson et al., 2009). There are many reasons for this including the difficulty of embracing change from a professional-led, illness- and symptom-centred care to a client-centred, strengths-based empowerment model (Future Vision Coalition, 2009; Shrank & Slade, 2007;). Perkins and Slade (2012) report a disjunction between policy and practice when describing the recent efforts to introduce recovery to mental health services in England. Le Boutellier et al. (2011) developed a conceptual framework from existing international guidelines around how recovery can be introduced to services. The framework consisted of 16 themes grouped into four practice domains; promoting citizenship, organizational commitment, supporting personally defined recovery, and the working relationship.

One of the central tenets of personal recovery is that the person with mental health problems has control and choice in their lives. This includes choice around the services

they receive and a degree of control over how the services are delivered. Slade (2012) suggested that a move toward supporting recovery involves a re-organisation of power arrangements in services. Piat, Sabetti, and Bloom (2010) argued that change to a recovery-orientation requires an active leadership from decision makers in order to push through change. At the individual level, Davidson et al. (2006) highlighted concerns that mental health services and staff have about the changes associated with moving to working in a recovery-oriented way. One of the fundamental changes that staff find difficult is that of the change in the nature of the relationship between themselves and service users (Borg & Kristiansen, 2004). Roles need to be re-negotiated, and changes in practices and service structures are required. Borg and Kristiansen (2004) found that the staff that service users found most helpful were those who could deal with the complexities of the change process and those who conveyed hope, shared power and were available when needed. Hicks, Dean and Crowe (2012) suggest that staff move toward developing supportive working alliances with service users, while Hobbs and Baker (2102) highlight the importance of being able to instil hope. Bird et al. (2011) developed an intervention aimed at increasing the focus of services on supporting personal recovery by fostering recovery-promoting relationships between staff and service users by a) understanding values and treatment preferences of service users, b) assessing and focusing on their strengths and c) supporting personally meaningful goal striving.

It is important to acknowledge that many social and historical barriers to working in true partnership exist (Holttum et al., 2011). Recovery-orientation requires that service users are treated as equal partners in their care and that services be used by them as they require; 'on tap, not on top' (Shepherd, Boardman & Burns, 2010). This requires a change

in how service users and staff 'position' themselves in services. According to positioning theory a 'position' is a combination of personal attributes, as socially defined, which impinge on the possibilities that are open to a particular person. A 'position' exists as a pattern of beliefs in the members of a group or community and is social in the sense that one member's belief is similar to that of another (Harré & Moghaddam, 2003), is maintained interpersonally in groups and institutions and is relational in that if one person is positioned as power 'ful', another is comparatively power 'less' (Harré & van Langenhove, 1999).

Rationale for the present study

The move to recovery-oriented practice, despite strong governmental and policy endorsement, has proven problematic at the service level. This study aims to gain a deeper understanding of the ways in which the change process is voiced by both service users and staff and to elucidate some of the social mechanisms at play via the language being used. Foucauldian Discourse Analysis (FDA) seemed an appropriate methodology because recovery-oriented working involves a change in how power is negotiated in the relationship between service users and staff, and power is also the subject of FDA. The research questions that guided the present study were:

- i. What discourses are drawn upon by service users in talking about recovery?
- ii. What discourses are drawn upon by staff in talking about recovery?

Methodology

Service Context

Two pre-existing geographically adjacent secondary care mental health teams were joined in the year prior to the beginning of the study to become a Support and Recovery Team based in a London borough. This was seen by the service as an opportunity to introduce a more recovery-oriented way of working. To that end the team introduced the Recovery Star (Mental Health Providers Forum, 2008), a tool that focuses on areas of personal recovery in which service users can define goals and progress and make a recovery action plan that they can complete with the support of staff. Recovery groups were also introduced by the service. In these groups service users are introduced to the Recovery Star and have an opportunity to think and talk about theirs and other group members' personal recovery.

Participants

Two service user focus groups (five male and four female) and one staff focus group (one male and four female) were held at the beginning of the study when recovery-oriented practices were being introduced to the service and again six months later. Six service users were White British, one Black British and two were White European. Two of the staff members were White British, two White Irish, and one Black-Caribbean (see Table 1). Two service users and one staff member were unable to attend the second round of focus groups. Service users were included if they were in the Support and Recovery Team, and were involved in one of the recovery-oriented practices recently introduced to the team

(i.e. were participants of a Recovery Group or were using or intending to use the Recovery Star). A diagnosis of psychosis was also a requirement for the service users, who were recruited through care co-ordinators.

TABLE 1: Demographic data

Participant*	Age	Ethnicity	Gender	Diagnosis
<i>Louise</i>	50-60	White British	F	Bipolar Affective Disorder
<i>Vera</i>	50-60	White British	F	Catatonic Schizophrenia
<i>Paul</i>	60-70	Black British	M	Not available
<i>Larry</i>	20-30	White British	M	Hebephrenic Schizophrenia
<i>Ryan</i>	40-50	White British	F	Schizoaffective Disorder
<i>Sarah</i>	50-60	White European	M	Bipolar Affective Disorder
<i>Mark</i>	30-40	White British	F	Not available
<i>Pam</i>	40-50	White European	F	Not available
<i>P.J.</i>	20-30	White British	M	Paranoid Schizophrenia

Staff*	Age	Ethnicity	Gender	Job title
<i>Nigel</i>	50-60	White Irish	M	Occupational Therapist
<i>Helen</i>	30-40	White British	F	Psychologist
<i>Maria</i>	30-40	Black Caribbean	F	Community Psychiatric Nurse
<i>Jill</i>	50-60	White British	F	Bridge Builder
<i>Mary</i>	50-60	White Irish	F	Community Psychiatric Nurse

*Pseudonyms used

Care plans were available for all service users other than P.J and Mark. Only one recovery star was available, from Pam.

Design and Epistemology

Focus groups were held six months apart. The aim was to gather data from different sources in order to capture different discourses that become available in different contexts

and once the recovery practices had a chance to become embedded in the service. A qualitative approach allowed a detailed focus on the introduction of recovery-oriented practices and how that was experienced by service users and staff. The focus of the study was the language and discourses used and how that reflected the positioning and power in the relationships between service users and the service during the adoption of recovery-oriented practice. Available Recovery Star notes and action plans (Appendix 14) and service user care plan materials were also analysed to identify how the service users and staff drew upon discourses and social positioning, with particular emphasis on talk about recovery-related issues, such as change or lack of change. Change may apply to staff as well as service users in that staff are attempting to move towards a strengths-based recovery model (Oades, Crowe & Nguyen, 2009). As such a Foucauldian Discourse Analysis (FDA) was used to analyse the language and discourses used in the focus groups when talking about the change and importantly how those discourses position service users and staff. This methodology sits within a social constructionist paradigm and assumes that language constructs social reality and is linked to social context (Parker, 1998). Discourses exist in particular social and historical contexts and ideologies, and allow people to adopt particular roles and 'positions' which open up or close down particular opportunities for action and affect participants' subjective experience (Willig, 2001). What people say can reflect wider systems of meaning in society. Ultimately the dominant discourses legitimize power relationships and institutional practices and over time come to be seen as 'truths' and 'taken for granted' (Foucault, 1982). However, these 'taken for granted' ideas and truths can be questioned and challenged by actions and counter-discourses (Parker, 1998).

Service user involvement and focus group schedule development

The focus group schedule was developed based on extant recovery research and schedule development guidance (Robson, 2002; Slade, 2009), to elicit conversation around service users' experience of mental health problems and experience of the service move to recovery-oriented practice (Appendix 8). It was presented to and reviewed by the Salomons Advisory Group of Experts by Experience (SAGE) and recommended changes were incorporated. It was also presented to a local service user research group who provided feedback and recommendations.

Procedure

Participants were recruited through their care coordinators, who provided them with an information sheet (Appendix 4). Once service users agreed to be contacted the researcher made telephone contact at least 24 hours later to clarify any information and to answer questions. Written consent was obtained before the first focus group and participants were told that they could withdraw at any time (Appendix 6). Staff were nominated by the service research supervisor and approached with an information sheet by the researcher (Appendix 5), who also attended a service business meeting to present the research proposal and invited staff to participate. Consent was obtained before the initial focus group (Appendix 7). Focus groups lasted for between one and one and a half hours and followed the focus group schedule format. The groups were homogenous in that service users and staff were in separate groups. The questions focused on service users, their mental health problems and services and their ideas around recovery. For staff questions focused on their perceptions of service users' experience of mental health problems and

how services support service user needs and the move to recovery-oriented service provision. All sessions were audio-recorded and data were transcribed and analysed in a reflexive way; using an iterative process of reading and re-reading of transcripts and then applying the six steps for Foucauldian Discourse Analysis as recommended by Willig (2001), which were used to structure the reporting of results. The methodology was used to 1) find the discursive object in the text, 2) situate the discursive object in other, wider discourses, 3) explore the action orientation (function) of the discourse, 4) discover the subject position offered by the discourse, 5) explore the possibilities for action opened up by the subject position, and 6) to think about the effect of that subject position on subjectivity. A reflective research diary was kept throughout the process and thinking and ideas developed using this and both service and academic supervision. Available Recovery Star notes and action plans and Care Plans were obtained through care-coordinators and also analysed using FDA.

Ethical considerations

Ethical approval was obtained through London North West Research and Ethics Committee (REC) (Appendix 2). Research and Development (R&D) approval was obtained from one local NHS trust (Appendix 3). Important areas for consideration were anonymity, storage of data, and confidentiality in the focus groups. A report was prepared and sent to the REC and R&D committees (Appendix 10).

Quality assurance checks

It is acknowledged that the results are one reading of the texts and that there are other ways in which it could be *authored*. The researcher took steps to ensure the quality of the results, as outlined below.

- a) Bracketing – Periodically, the researcher reviewed the data to investigate whether biases were entering. As a trainee clinical psychologist with previous experience of working in both recovery-oriented and non recovery-oriented services and a belief that recovery-oriented practices are more helpful for service users the researcher needed to be mindful of potential interpretative bias (Fischer, 2009), and of the discourses used to construct his own knowledge claims.
- b) Data Auditing – Discourse analysis codes and interpretation was audited by the academic supervisor who had experience using FDA.
- c) Reflexive Diary – The researcher kept a reflexive diary which enabled tracking and monitoring of the inevitable changes in thinking and also enabled reflection on and evolving comprehension and revised understanding of the emerging discourses (see Appendix 13 for extract).

The above steps, the author hoped, improved the quality and reliability of the analysis (Yardley 2000; Williams & Morrow, 2009).

Results

Two overarching discourses emerged from the texts; a medical discourse and a discourse of personal recovery. There was a great tension between the discourses which impacted on subject positions of service users and staff, as presented below. Firstly, the dominant medical discourse and the resultant subject position of dependent on services and not responsible will be demonstrated. Then I will show how a personal recovery discourse positioned service users as hopeful and staff as facilitative. Thirdly, I give examples of where the medical and personal recovery discourse were in tension with each other resulting in the positioning of service users as either chronically ill or hopeful, deserving of care or ready for discharge. I will then show how the lack of availability of a personal recovery discourse can leave service users subjectively feeling confused and frightened in the face of impending change. There were no obvious differences in discourses between rounds of focus groups.

Medical Discourse

A strong medical discourse ran through focus groups of both service users and staff, along with service user care plans, while the available Recovery Star (from one service user) invoked a less medical discourse. Mental illness was constructed as biological in origin, and social or environmental constructions were limited. Conversations drew on the wider epistemologically dominant biomedical discourse of disease and cure and 'clinical' recovery (Slade, 2009), which legitimised a medical understanding of mental health placing the service users in the subject position of 'patient'. A medical discourse of illness and cure

results in positioning the service/staff as doing things to people to make them better rather than service users doing things according to their own life-goals. The medical discourse therefore can also be said to 'position' service users. It is not necessarily a deliberate and thought-out social action but it is the consequence of staff/ the service assuming that what they should be doing is making people better. In the patient subject position the service user is not given the opportunity to question decisions or to offer alternative explanations for their experiences.

Service User Group1- Round 1

Paul: The doctor when you are in hospital and he has the chart and... he's got so and so and so and so (diagnosis)...

Facilitator: and have you had any help with that?

Paul: I've had help in the past. I've had help in the past. I mean I've had my medication changed many times. You know. But this time they have hit the nail on the head... they have found the right one.

This construction is also true of staff as evidenced through the discourses used in Ryan's care plan. Here Ryan is positioned as an 'outpatient' with a diagnosis of schizoaffective disorder and the service is positioned as needed to intervene with medication and psychotherapy to "optimise his functioning". This positioning is in conflict with a recovery-oriented positioning of service users being empowered to have choices

and to direct their own care (Davidson et al., 2009). This discourse could also be seen to perpetuate the dominance of hegemonic medico-psychiatry and the mental health service as an oppressive institution.

Extract from Ryan's careplan:

Problem	Intervention/ Actions and frequency	Anticipated Outcome and Client's view	Main person responsible	Planned/ actual start date, actual end date
Mental Health Diagnosis of schizoaffective disorder	Outpatient appointments as required. 6 monthly CPA reviews. 1-2 weekly contact by xxx [Care co-ordinator].	For Ryan's mental state to reach its optimal level of functioning.	Not completed	24 Jan 2012.
Medication	Medication – Sodium valproate 1000mg at night Quetiapine 300mg	To take medication as prescribed	Not completed	24 Jan 2012
Psychotherapy	R attends twice weekly psychotherapy	His view: He is very happy about this. "To shift my depression and to gain insight into interpersonal relationships".	Not completed	24 Jan 2012

For more careplan extracts see Appendix 15. Pseudonym used.

Mental illness is also constructed as the same as physical illness. This again draws on the wider discourse of biomedicine and positions the service user as a passive recipient of care. No opportunity for action is opened up because the legitimisation of the biological framework is not questioned. This is discourses as the 'taken-for-granted' notion that there is such a thing as mental illness 'like any other illness', that is a disease of the brain and it can be treated by pills that fix chemical imbalances (Moncrieff, 2007), as can be seen in the staff focus group extract below.

Staff – Round 1

Facilitator: How do you talk to service users about their mental health problems?

Nigel: and if I had a mental illness I'd want some evidence that might get me to really believe it.

All: mmhh

Jill: there's no difference between me or you or someone with diabetes. There's no difference.

The 'patient' subject position becomes a way of speaking within a psychiatric discourse and does not allow space for a more social understanding of people's mental health problems in which service users could draw on explanations around abuse, disadvantage and discrimination. It has been argued that diagnoses of schizophrenia and attachment disorder are unhelpful and inadequate ways of understanding people's life experiences and difficulties, rendering life experiences of trauma, exclusion, and abuse as meaningless (Boyle, 2011).

When recovery is constructed as 'clinical' recovery (Slade, 2009) it draws on the wider medical discourse and is strongly associated with alleviation of symptoms and a return to previous functioning. The service user is again in the subject position of patient and their experiences are not thought of as meaningful.

Service User Group 2- Round 2

Facilitator: and so what does recovery mean then to you?

Sarah: getting well again. Coming to...

Pam: getting better

Sarah: coming to a ... feeling more... coming away from this illness.

Later...

Facilitator: How do you think about recovery?

*P.J.: Well it's about getting back to normal and having no more symptoms...
being 100% better.*

This discourse of clinical recovery directly hampers the adoption of the personal recovery discourse as it constantly reconstructs service users as passive recipients of care and staff as carers and curers rather than facilitators of personal goals and aspirations.

When recovery is discoursed as clinical recovery, returning to previous functioning and associated with the alleviation of symptoms it also has the effect of positioning service users as dependent on services and not having responsibility. This closes down opportunity for service users to take positive risks toward their recovery and to self-manage their lives, again rendering the service user a passive recipient of care.

Staff - Round 1

Mary: I think there should be a rotation of clients personally, because I think clients get dependent on the one person. Especially as in the past when they have been with you for 10 and 11 years do you know what I mean?

Facilitator: do you think it would be easier for them to move on then?

Maria: I think it's difficult because if you have a care co-ordinator who has worked with you for a very long time you know your clients better, you spot their symptoms quicker, most of them, some of them don't have any insight into their illness.

Mary: I agree but there is a dependency then.

Maria: there is yes there would be dependency

Helen: would it be up to the cc to break that? And take a risk and I think it's the risk you have to take with clients. Because we are afraid to take a risk with them I think... for fear.

Here Mary believes that service users become dependent on the same care co-ordinator unless there is a change every so often but Maria, coming from a caring position, is afraid that service users would not appreciate change. However, Helen realises that without taking risks with service users they remain in the subject position of needing services and are likely to be with the service '10 or 11 years later'.

At the same time staff are in the subject position of needing to do something to the service user and so they end up doing things that the service user might reasonably do for themselves. This can be seen both in the talk of service users and staff.

Staff – Round 2

Maria: it depends on the ability of the client. Cos with some clients you have to make follow up with benefits, you have to help them complete the form and even going to MIND you have to organise that for them. So those are the things which they are used to us doing for them.

Helen: ya but...

Maria: as messages were being sent to me that it's not been completed so please complete and give my own view about their diagnosis and their difficulties.

Jill: well they are probably not the clients that would be discharged - that would be recovered. If you have to do everything for them they probably wouldn't be the ones. They would be the chronic ones that wouldn't be recovered, wouldn't they?

Later...

Maria: well even those you feel sometimes they are able to do something. They think its care coordinator responsibility. For example, xxxx she can actually fill the form but she was like pushy, no you need to do this and I was saying to her I'm only doing you a favour that is like.

The ways of talking and sense making that the subject position of dependent offers to the service user are passive and work to endorse a medical understanding, privileging a biological understanding over a social one. In this position the 'patient' can be said to be drawing from a discourse of acceptance in that the discourse does not offer the service user a language to question or resist the biological interpretation of their mental health problem and removes personal responsibility.

Personal Recovery Discourse

Recovery was also constructed as personal recovery drawing on the wider discourse of service user involvement and the civil rights movement. Like the medical recovery discourse, this personal recovery discourse was used by both staff and service users, but much more by staff. When service users are positioned as 'equal' and involved in their care they are given the right to have their personal aims and objectives respected and to ask questions about their care. The subjective experience associated with achieving personal aims and goals with support from the service is hopeful, as explained by P.J. in the following extract where he spoke about his historic fear of psychiatrists.

Service User Group 2 – Round 2

Facilitator: What has changed then?

P.J.: Like I say I was scared of psychiatrists but I've got a chap now that I feel a lot more relaxed about seeing.

Facilitator: good

P.J.: and I actually went to him with xxx [psychologist] to ask him some questions instead of him asking me.

Facilitator: ya? that's really good, and how does that make you feel?

P.J.: ya that helps. I feel like I've a lot of support now. I'm happier.

Extract from Pam's Recovery Star notes:

In the Recovery Star the service user is asked to think about important areas of their life and to rate how they think they are doing and what they could do in the next 6 months to help them to achieve their goals. They also make some notes on points that came up in the discussion with the staff member.

1. Managing Mental Health

Reading number: 4

Notes:

- I will ask Helen to help when I need her (psychologist from staff focus group).*
- I would like to cope better with the voices.*
- I will go to church to help me.*
- Helen will arrange a meeting with the priest.*

When using the recovery star Pam was able to draw on a personal recovery discourse and to adopt the subject position of being empowered to prioritise her personal aims and goals.

Service User Group 1 – Round 1

Louise: when we were first told we were going to be a recovery group it was staff and users invited to this lunchtime buffet to discuss it. And he actually brought, sent a poem along. I'm sure you will find it amongst the files. It was all about 'I'll recover when I want to recover'.

Facilitator: ya

Facilitator: in your own time

Louise: it came right over in his poem. If you can find that.

Facilitator: ya, I will ask.

Louise: there were so many people staff and all that applauded that.

Here Louise constructs recovery as personal recovery that happens in the time period that the service user sets out and not the limit set by the service. This positions the service users as capable of using services when they need them, opening opportunities for support on their terms. So when a discourse of personal recovery is used over clinical recovery, possibilities and potential are opened up. Depending on the discourse used different meanings and possibilities are made available for service users.

Tension between medical and personal recovery discourses

Often there was a tension between the discourses. One example of the tension between a hopeful recovery discourse and a more medical clinical construction of recovery emerged when talk was oriented to staff roles and responsibilities and possibilities for change. When staff drew on hopeful discourses they were freed up to think about alternative ways of working. This happened when recovery was constructed as personal recovery and staff drew on the wider service user rights discourse, allowing opportunity for alternative ideas to emerge.

Staff – Round 2

Facilitator: what do you think your role is in a service user's recovery?

Nigel: well for me it's ...

Jill: social inclusion.

Nigel: well number one it's about giving them self belief because for me the principle of recovery is that 'you have more ability than you think, you don't need me to tell you what to do. You are an adult you are able to decide a lot of things'. I think it's about building their own capabilities.

Facilitator: ya it's like hope isn't it?

Nigel: ya that they are... Things can get better and it's driven by you. I'm here as your support. I won't do it for you. So it's about shifting the power balance as well. It's about 'I don't know it all. I may be qualified as a

mental health professional but I don't have all the answers. I can give my advice'.

Facilitator: that would be a huge responsibility... to think you should have all the answers.

Nigel: of course it is. I think that is more the old model. The old model without doubt, you came in here to get fixed. Have a lifelong support network that we are going to sort you out with. You were the doctor or the nurse and you knew. You know what's best for me. What do I know – I'm sick.

However, when staff constructed mental illness as chronic and hopeless, drawing on wider discourses of traditional conceptualisations of chronic disease both the staff and the service user are put in the subject position of being helpless. There was a lack of control against the powerful mental illness. A discourse of chronicity blocks opportunity for change and silences hope, enabling them to do only what the service will allow.

Staff – Round 1

Facilitator: So what is our role as a service and as workers to help recovery?

Mary: well, you know it makes me think is this going to be something we will have to come to terms with that we might have a group of clients that

we are never going to be able to get any further than maybe they are now. They are the chronic ones. Maybe...

Helen: and it feels really cruel to people to set people up to fail.

All: mmhh

Helen: if they are not able to do that.

Nigel: a bit like my own illness [physical illness]. That it's like a step back. You think god I'm back to square one. What was all the last treatment about, you know. I would have had a relapse. And then I'm thinking is this ever going to stop? ya what's the point in the treatment and you know... what else have I to do? If I've tried this and it hasn't worked and now you are telling me I need to do it again? It's a bit wearing...

This discourse renders the service user position as hopeless and staff and the staff as helpless; some service users being positioned as 'too ill to help', not giving them any reason to act/ strive for goals, and leaving them feeling helpless against a powerful mental illness. This discourse continually reinforces the fixed mindset that there is no point in changing as nothing is going to work and we might as well just keep doing what we are doing. Here the mental health service can become an oppressive institution that disempowers service users. This may not happen at a conscious level, but is the result of the assumption that services should be 'making people better' where the illness is

amenable, and where it is not, to continue supporting and supplementing what people cannot do for themselves.

Staff – Round 2

Facilitator: I don't have the impression that the recovery star is used very much really?

Nigel: no

All: no

Nigel: it's not given [priority]

Facilitator: the recovery star itself isn't something that's pushed or?

Jill: Ya. No.

Nigel: not pushed enough but as I say it's going to change. It's gonna be pushed and I think that's the only way to ensure we will be more focused on it is by making it a priority it will come down from the top saying you need to be using it.

Here we see that staff are positioned as helpless and cannot complete the recovery star unless it is mandated by services. Discourses of helplessness to change working practices close down opportunity for change and directly hamper the adoption of recovery-oriented ways of working.

Throughout the discussions it was apparent that some of the service users did not have a personal recovery discourse available to them. The staff seemed to oscillate between medical and personal recovery discourses. Staff also seemed afflicted by a 'bystander effect' (Chekroan & Bauer, 2002), in that they did not appear to feel they had any role in explaining about recovery to service users, even though they observed that service users did not understand it.

Staff – Round 2

Helen: but I don't think that people on the team do know they are in a recovery team.

Jill: [overlapping..] I agree with you. Because it used to be the old teams and in the old teams it was long term intervention teams and they thought they were in the long term intervention team for life.

All: mmhh

Jill: And the only thing what's changed to them is the team name.

All: mmhh

Helen: and all that's changed for them is the headed note paper. I mean obviously hopefully our style of working a bit but...

RECOVERY-ORIENTATION IN SERVICES

Maria: I personally feel they don't understand what is meant by recovery. They haven't got a clue. And i don't think we have actually explained to them what it means and what are the changes.

Helen: they know the building. They knew their care co-ordinator.

Here staff recognise that service users do not have a personal recovery narrative available to them but it is also apparent that they do not see it as their responsibility to change that, and again are in the subject position of helpless.

Focus Group 2 – Round 1

Facilitator: what does recovery mean to you? When you hear the word recovery what do you think?

Mark: getting better like trying to reduce my clopixon like.

Facilitator: and how does everybody, other people see that idea of recovery or have ye heard of the recovery model?

Larry: Module?

Facilitator: model.

All: no

What becomes clear from Larry and Sarah's talk is that a discourse of personal recovery is not available to them. Speed (2011) argues that it is not the person who uses a particular discourse that sets the parameters for talking about a particular topic (e.g. recovery-orientation), but the discourses that are available to be used. When service users do not know what personal recovery is they do not have the language available to them to talk and therefore think in another way, thus closing down the opportunity for the personal recovery to even begin.

Another tension emerged when recovery was constructed as readiness for discharge from services and the service users were positioned as either ill and deserving of care or not ill and ready for discharge. This discourse is likely to have emerged when the service changed from a longer term intervention team to the recovery team and an expectation of service involvement for two years was implemented. This talk draws on the wider discourse in service delivery of payment by results, with its attendant emphasis on throughput and outcomes (DOH, 2011b). There is also a sense here that service users and staff are drawing on the wider social discourse of big government and a dependency culture (Hansard, 2012). If the service/government provides too much help people are not encouraged to work and be 'contributing'. If someone is ill they deserve help but if they are not then they are not deserving and should be working and contributing to society. Here we see a tension in the discourses where the recovery discourse may be being confused with a wider anti-dependency discourse.

Staff are in the subject position of needing to do something to make the service user 'ready for discharge', which is usually being non-symptomatic. This subject position puts pressure on staff to 'fix' service users, but at the same time they are aware of the

meaninglessness of the target, reflecting some of the confusion or 'madness in the system' (Newnes, et al., 1999).

Staff – Round 1

Nigel: ...particularly in the light that our target in the recovery team is 2 years.

All: mmhh

Nigel: and as Helen has said I don't think we are not going to have a group whose recovery will take much longer than 2 years. And as you said earlier if some people had been around for 20 years, it's gonna be quite difficult for those to think that you can get them through the new hoop so to speak, in 2 years. I mean I think our target is something like 70% should have come through in 2 years. And I think at the end of 2 years it will look much... nothing like that.

All: mmhh

Nigel: It's the trust target for recovery teams.

Helen: but that ruins the whole concept of recovery in a way.

All: Mmhh

Helen: because the whole idea is that it's individual. Someone doesn't need to leave services to go on a journey of recovery. So the idea that recovery means you recover in 2 years kind of defeats the whole idea of recovery.

Service users are in the subject position of 'given two years to be fixed'. Again at one level this gives opportunity to move on but also it is imposed by the service and service users are left disempowered. They may be drawing on the wider social and political discourse of ill/deserving of care or not ill/not deserving. Since the personal recovery discourse and all its associated practices are not available to service users they draw on what is available (Speed, 2011). Without a personal recovery discourse they drew on the medical discourse of being 'not ill' and the wider social discourse of 'not deserving of care', and interpreted discharge as abandonment by services.

Service User Group 1 – Round 1

*Facilitator: Can you remember the beginning when it did become a recovery model?
What were you told about it or what way was it communicated to you?*

Louise: well it's in a gradual way. Services started to close down. The way they talked about it then was 'empowerment'.

Facilitator: mmh

Louise: we are going to empower you to... ya it's ... what it said to me was 'we are no longer taking responsibility for you'

Facilitator: mmh

Louise: you are being empowered now to take responsibility for yourself

Facilitator: ya

Louise: changes took place and I know that several of my friends I've made over the years felt extremely.. am.. frightened

Facilitator: really?

Louise: panicked, literally panicked.

Facilitator: by the idea of recovery, is it?

Louise: the idea of having those things taken away and then being suggested that you form self help groups.

A discourse of personal recovery and equality in services is in opposition to one of medical and clinical recovery, potentially because of the implications for hegemonic medico-psychiatry, and indeed the status and roles of other clinical staff including clinical psychologists. A shift in the power in the relationship may be anxiety-provoking, not only for those professionals normally constructed as holding most power, but also for others if they are not ready to take on additional responsibility for new risks, such as in facilitating positive risk-taking (DOH, 2007, 2009). This may be one reason why there seems to be such strong tensions between the discourses.

Discussion

This study set out to examine the discursive constructions of recovery by service users and staff and the discourses drawn upon during the change in a service when recovery-oriented

practices were being introduced. Recovery was constructed as both clinical (medical) and as personal recovery. These constructions positioned service users as dependent, passive and hopeless or empowered and hopeful, and staff as helpless or facilitative. It was also apparent that a discourse of personal recovery was not available to all service users. Staff oscillated between the constructions of recovery as clinical and personal. Discourses of both service users and staff often served to reproduce the mental health service as a place where service users came to be fixed, or could not be fixed and therefore needed to be protected and supported in perpetuity as 'the chronic ones' (Mary, p. 27; Jill, p. 19). There is evidence of the personal recovery discourse in great tension with the medical model discourse and having difficulty finding a footing, with personal recovery constantly undermined by the power of the medical discourse. This raises the question of whether there is a need for more than training of staff in personal recovery, but in addition a direct and sustained challenge to medical model hegemony, and whether this is possible without it becoming a personal attack on psychiatrists.

When recovery was constructed as clinical recovery, service users were positioned as dependent, passive and hopeless. Opportunity for positive action was closed down and service users were left feeling hopeless, the staff helpless and the service unchanged. This is consistent with a recent review of the impact of viewing mental distress as 'an illness like any other'. Angemeyer, Holzinger, Carta and Schomerus (2011) concluded from reviewing relevant research that rather than reducing stigma, this view of mental distress can actually increase it. It could be argued that aspects of the clinical recovery discourse served to provide hope of a return to previous functioning and offer service users one way to understand their mental health problems. Service users reported that medication can play a role in their

recovery journeys (Piat, Sabetti & Bloom, 2009) and the containment provided by staff and services who aim to 'make people better' may be important to some service users. However, when recovery was constructed as personal recovery drawing on a civil rights discourse, service users were positioned as more empowered and hopeful, staff as facilitative and the possibility for change such as through using the Recovery Star became real possibilities.

It is argued here that there are numerous versions of reality that are created through discourses and practice and that human subjectivity is constructed through language (Parker 1998). Some discourses are given a more legitimate status and are accepted ways of being, depending on the support given by powerful institutions, but no one way of being stays constant; the social construction of reality is characterised by constant change and transformation (Willig, 2001). If the service user does not have the 'personal recovery' discourse available to them, fewer possibilities for change are opened up. In this sense 'it is the discourse, not the subject who speaks it which produces knowledge' (Hall, 1997). It is not the person who uses a particular discourse that sets the parameters for talking about a particular topic (e.g. recovery-orientation), but the discourses that are available to be used (Speed, 2011). The discourses that are available are delimited by social and political forces and depend on the particular culture, period of history and political framework within which they operate. The dominance of the construction of recovery as clinical recovery drawing on a disease model of mental illness in this study is indicative of the power that that particular epistemological position has in our culture and in this period of history.

In the current study the team was at a very early stage of introducing recovery-oriented practices. The staff oscillated between constructing recovery as clinical and personal recovery and service users drew more from the biomedical discourse of clinical recovery. We know from organisational change research that successful planned change messages should include a shared understanding at all levels (Bartunek et al., 2006). Until staff and service users are using a shared language around recovery the change process will struggle. The under-use of the Recovery Star, as evidenced by the availability of only one for the current study, potentially demonstrated that staff were not fully invested in recovery-oriented practice at this stage. One recommendation is that service users be fully involved both in the provision and receiving of recovery-specific training. It will also be important that people with lived experience of mental health problems are actively sought out and employed by the service (Shepherd, Boardman & Burns, 2010).

Clinical and theoretical implications

The results of the present study have far reaching clinical implications. Services need to introduce a language of personal recovery to their work practices and to become more aware of the often unintended social positioning effects of a medical discourse. Dominant discourses can be contested and changed (Howarth, 2000). There is a challenge for services to incorporate a personal recovery discourse from which service users can set out an alternate subject position which can offer them different ways of talking and thinking about their emotional distress whilst enabling them to relinquish old discourses with which they have become familiar. These alternative discourses should infiltrate all contacts with

service users so that they too are able to have a discourse of personal recovery available to them and to recognize the negative aspects of habitual medical discourses.

The relationship between service user and staff will be paramount to the successful implementation of recovery-oriented practice. Some work has been done on how staff should approach sessions with service users including using a coaching stance (Bird et al., 2011), creating a supportive working alliance with service users (Hicks, Deane & Crowe, 2012) that instils hope for personal recovery (Hobbs & Baker, 2012) rather than fear of abandonment. Based on the results of this study it seems important that both positioning theory and systems theory be held in mind when services introduce changes to working in a recovery-oriented way. An ability to be mindful of power dynamics in relationships and being open with service users about this is more likely to strengthen the working alliance.

Future research questions

Future research should examine more individualised meanings of the change process and focus less on the power relationships which FDA prioritises. Interpretative phenomenological analysis would be a helpful methodology here. Quantitative studies over time using the available measures of recovery and recovery-orientation in services would enable a service to track its progress with implementation of recovery practices. Longer term data that measure outcomes that are more relevant to personal recovery are needed. Recovery-oriented constructs such as empowerment, quality of life and community engagement should be routinely measured in services and less emphasis should be placed on outcomes like symptom remission. Further discourse analysis may be helpful in looking

at news reporting on mental distress, and in how it is discourses in drama, since these may both be influential in maintaining a disease and dangerousness discourse.

Limitations

It is likely that the staff that volunteered for the study had an interest in the recovery approach and the service users recruited had been involved in recovery practices. Thus the sample may not be representative of the wider team. It would also have been helpful to have focus groups with family members and service managers. Although FDA was a suitable method for this study, it could be argued that discourse alone is not enough of a basis from which to elucidate or make comments on subjectivity. The mere availability of a subject position, provided by a discourse does not account for why some people become more emotionally invested in a particular position. FDA does not account for the motivation to take up or be attached to a particular subject position.

Conclusion

This study suggested that service users and staff construct recovery as both medical and personal recovery, which impacted on the subject positions of both stakeholder groups. There was a tension between the discourses with the recovery discourse struggling to find a foothold. Adopting a recovery-orientation should lead to service users being positioned as more influential in decisions about their treatment and modes of support from the service, and services less likely to dictate their treatment. However, this can only happen if the recovery-orientation constitutes a widely shared discourse with all its assumptions and associated practices. If it only involves some use of new words but keeping old ways of talking in key contexts such as discussing care plans, real change will be hampered. The

problematic aspects of the medical discourse also need to be highlighted, not as an attack on psychiatry but to be aware of how it can position people socially and how those positions impact on the potential for personal recovery.

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Critical Appraisal

Word Count: 1944

QUESTION 1

- 1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?***

I had very little experience of qualitative research before I began this project. I had done some thematic analysis for my quality improvement project but nothing on this scale. I had a steep learning curve to manage as I found myself in a position of needing to develop a whole new language of qualitative research. Foucauldian Discourse Analysis (FDA) does not make assumptions about knowledge or truth. I had to be very aware of my positivist assumptions and to lay them on the table for scrutiny before I began and all the way through the project. I found I needed to develop my linguistic skills to get the most out of the data and to be able to relay the results in a meaningful way. I had a lot of experience of quantitative research as I completed a PhD from a very positivist stance. I learned to be more aware of my assumptions and biases particularly as Foucauldian Discourse analysis does not aim to understand the true nature of psychological phenomena but how particular versions of truth are constructed through language. The researcher authors rather than discovers truth and knowledge. A reflexive awareness of how you construct your knowledge claims and of the discourse drawn to construct it is therefore especially important in FDA. This is a very different assumption from those made during my PhD where the goal was to discover the truth about animal behaviour. On reflection I see the benefits of both ways of thinking and I think depending on the question the researcher is asking either position can be more or less appropriate. I learned about the importance of language and how discourses can impact on people in many ways including unintended

ways. Overall I learned respect for qualitative research. I must admit that before I started this project I believed that it was somewhat 'softer' (whatever that means/meant) than the quantitative methodologies, but I have since revised my assumptions, and have shifted my personal epistemological positioning toward a critical realist stance.

I learned a lot about the ethics process and in particular needed to be mindful of the ethics of service user involvement. My project was on recovery-orientation in service and user involvement was a very important aspect. I was wary of tokenistic involvement and made every effort to make it meaningful. My supervisor was chairperson of a service user research group to which I presented my proposal and also a member of the Salomons Advisory Group of Experts by Experience (SAGE), whom I consulted. It was not possible for me to involve service users at every point of the study and this is a limitation of the project.

I learned to do research in a clinical team. This was quite challenging as I was coming in from outside and not employed by the team, and so there was a question around 'who is this research for?' and 'who will benefit from it'? In the early stages, I attended a business meeting and enthusiastically presented my project expecting to be welcomed, that everyone would want to take part and be grateful that I was doing the research. However, I learned that research is not regarded as valuable by all team members and that professionals' priorities did not always match mine. I eventually learned through a long recruitment process that it is important to nurture relationships with colleagues and professionals when doing research in services. I plan to present the findings of the research to a group including staff and service users.

CRITICAL APPRAISAL

I became a member of the Recovery Research Network (www.researchintorecovery.com) at the beginning of the project. This was very valuable as it put me in touch with researchers from many parts of the country who were doing research in the area of recovery. I attended three 6-monthly meetings during which I heard many presentations and discussions around the state of the recovery research world. I plan to maintain contact with this group and use it to link with recovery researchers.

I presented preliminary findings of my research at the International Refocus on Recovery Conference in Kings College London in March 2012 (Appendix 17 for slideshow). This was an invaluable experience where I got to share my results and to have discussions with international experts in the area. The chair of my session was Dr. Lindsay Oades, who I cited many times in my project. It was valuable to be able to put faces to names and to have one to one discussions about the research. It gave me confidence in my results and project and I have kept in touch with many of the delegates.

I presented my project at a trust research day with my external supervisor. This was a good opportunity to see what research was happening at the service level throughout the trust. I am keen to keep research as an aspect of my job as a clinical psychologist and will draw on days like this to meet like minded research psychologists.

I also presented my focus group schedule to a service user research group. I framed the presentation as a training session on discourse analysis. In return for their consultation I was able to provide them with something useful. I got some good feedback and useful suggestions were made that improved the quality of my research.

QUESTION 2

2. If you were able to do this project again, what would you differently and why?

I got feedback from the service user research group that it would be good to include a family member focus group. This was a very good idea but I did not have the capacity in the project to do it, although if I were to run the project again I would include it in the proposal. I would also like to have had a management level focus group as it would be interesting to analyse the discourses at that policy level, which ultimately have a large impact on service provision.

On reflection I would hold the focus groups outside of the service setting. The project looked at the power relationships between service users and staff and some of the results pointed to how the service can position service users as 'patient' and dependent on services. By holding the groups in the service building, it is possible that I was positioned as staff, and in a position of power during the focus groups and the service users as patients. This could potentially have impacted on the types of conversations that took place. If I had the chance again I would hold the groups in a community setting.

I would have left more time to analyse the results. I underestimated how long this would take. Again I think this might be because of my quantitative research experience when SPSS did most of the work for me. The reflexive nature of this work requires time spent with the data/text; for reading, thinking, re-reading and challenging thinking. I would have given myself more time to prepare for the recovery conference. I had a lot of work to do from January to March 2012 and I felt like other parts of my life were neglected.

I learned how to liaise with professionals in mental health services at a research level. However I feel that I could have maintained communication more regularly with the service manager during the project. The competing demands of the course meant that I did not always have the research at the forefront of my mind, especially in the second year. By the time the third year came there was a sense that I had lost touch somewhat with the team. If I were to do the project again I would pencil in more regular meetings and give more feedback along the way. This is also true of the service users. I had told them that I would feedback to them when I had analysed the results. The gap between then and when I will be able to do this was too long.

QUESTION 3

3. Clinically, as a consequence of doing this study, would you do anything differently and why?

The main influence this research will have on my clinical practice is in how I use language. The results show that the language we use and the discourses we draw from can have very large impacts on service users. I will make an effort to use less medicalised language such as 'diagnoses' and 'symptoms' and move to using language such as 'mental health problem' and 'distress'. I was mindful of this before I conducted the research but not of the implications for positioning and closing down of opportunity for service users.

I will also try to involve service user in more of my work. I have learned that peer workers will be an important element to the successful implementation of recovery-oriented practices. If I do join a recovery team in a professional capacity I will make it my aim to have service users employed as peer workers across the service.

I will be more person-centred, use a language of formulation over diagnosis with service users and the wider team and use a personal recovery discourse during all of my interactions with service users. I will make service user aims and goals central and be mindful of their wider social lives and relationships.

QUESTION 4

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

There are two quite different projects I would like to undertake. One is a large scale quantitative project to measure recovery specific outcomes such as quality of life, community engagement and empowerment of service users over time once a service has introduced recovery-oriented practices. It would be interesting to measure this across different service types. I would like to compare a community mental health team with a model of service delivery that was developed by service users and had service users as staff members, such as the clubhouse model. It would also be important to correlate these outcomes with measures of recovery-orientation in the service to see if services are facilitating the personal recovery of service users.

Secondly I would like to be involved in a participatory action research (PAR) project in which service users drive the change toward recovery-orientation. PAR calls for member participation (user involvement) in research aimed toward practical benefits of the people in communities and organisations (Fals-Borda, 2001). The objectives of PAR are the 'production of knowledge and action directly useful to a community' and empowerment through increasing participants consciousness of the problem at hand (Reason, 1994). To make this change happen service users need to be at the heart of the process, which

involves researchers and participants working together to develop goals and methods, and using the results in a way that will raise consciousness and promote change. It can also potentially change the social positioning (Harré & van Langenhove, 1999) of service users. Researchers learn something about the lived experience of the participants; how they perceive their strengths and problems, what and how they know about their group/community, how they experience change, both as active agents of change and also how they benefit from change at a larger service level. This would be a truly user led piece of research and would add immensely to our understanding of how recovery-oriented practice can be meaningfully introduced to mental health services.

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SECTION D: Appendices of supporting material

APPENDIX 1: LITERATURE SEARCH STRATEGY

The comprehensive literature search firstly explored the broad area of recovery and then focused on the move to recovery orientation in mental health services. The databases used were Psychinfo, Medline, PubMed, Cambridge and the Cochrane Database of Systematic Reviews databases from inception to June 2012. All databases were searched using a combination of the following search terms:

- Recovery
- Recovery orient*
- Mental health services
- Policy and change
- Practice and change
- Service user
- Recovery outcomes
- Working alliance

Combinations of these search terms using Boolean operators were employed to identify relevant papers. Reference lists of recent reviews were scanned and websites of service user and recovery groups were also searched. International governmental websites were searched for policy documents pertaining to recovery. Service websites were searched for practice guidelines pertaining to recovery. Specific recovery websites were also searched.

APPENDIX 2: RESEARCH AND ETHICS' COMMITTEE APPROVAL

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APPENDIX 3: RESEARCH AND DEVELOPMENT APPROVAL

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APPENDIX 4: SERVICE USER INFORMATION SHEET

INFORMATION SHEET FOR SERVICE USERS

Project Title: Recovery in xxxx

I would like to invite you to take part in the above study. It is a project that will investigate the kinds of changes that occur when your service introduces ways of working that help your recovery. Please read the information below in order that you have a good understanding of what the research would involve for you and also why I am doing it. If you have any questions feel free to contact me at the email address below, or ask someone at your service (xxxxxxx) to put you in contact with me.

What is this study about?

This study aims to understand what happens when a mental health service starts to move toward working in a recovery-oriented way.

What is a recovery-oriented approach?

Recovery is “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 with limitations caused by mental illness”.

Recovery-oriented practice attempts to make this happen with and for service users. In your service a number of things have happened to help the team become more recovery-oriented in its practice.

Do I have to take part?

No. This is entirely voluntary and you are free not to take part if you do not wish to. If you do decide to take part I will ask you to sign a consent form. Even after you sign the consent form you are free to withdraw at any time. The groups will be audio-recorded and the recordings will be used as part of the analysis of the study. During the group you will be asked to talk about your mental health and also about areas of your life that help with and hinder your recovery.

What will happen if I do agree to take part?

If you do agree to take part you may be asked to complete the Recovery Star (a brief questionnaire) with your key-worker. You will then be asked to join two focus groups, with 5-7 other service users, for about an hour and a half to discuss how you found the process and if it was useful or otherwise for you. The first focus group will happen in May 2011 and the next one will be six months later.

Is this study confidential?

Yes – only the research team (xxxxxxx) will have access to the audio-recordings of the focus groups and these recordings will be destroyed as soon as they have been transcribed. However, if you say something that makes me worried that you or someone else might be at risk, I may have to share this with relevant others. I will make sure that your name and any other identifying information is removed from the information I collect so that everything is anonymous. Only the research team will access your recovery star notes and care plans and you will be notified of this before it happens. I have received ethical advice around the running of the project.

What will happen to the results of the study?

The study will hopefully be published in an academic journal. Again, it will all be anonymous. If you would like a copy of the final paper you are welcome to have one.

If you would like any other information feel free to contact Dr. Ken Murphy (lead researcher) at km270@canterbury.ac.uk at any time.

APPENDIX 5: STAFF INFORMATION SHEET

INFORMATION SHEET FOR STAFF

Project Title: Recovery in xxxx

I would like to invite you to take part in the above study. It is a project that will investigate the process of incorporating recovery-oriented ways of working. Please read the information below in order that you have a good understanding of what the research would involve for you and also why I am doing it. If you have any questions feel free to contact me at the email address below, or ask someone xxxxx to put you in contact with me.

What is this study about?

This study aims to understand the way services users and staff talk about mental health and recovery when the service starts to work in a recovery-oriented way.

What is a recovery-oriented approach?

Recovery is “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 with limitations caused by mental illness”.

Recovery-oriented practice attempts to make this happen for service users. In your service this has already been happening in a number of ways. We are hoping to build on this work by using the recovery star and introducing a recovery group.

Do I have to take part?

No. This is entirely voluntary and you are free not to take part if you do not wish to. If you do decide to take part I will ask you to sign a consent form. Even after you sign the consent form you are free to withdraw at any time.

What will happen if I do agree to take part?

If you do agree to take part you may be asked to complete the Recovery Star with two service users from your caseload. You may then be asked to join a focus group with 5-7 other staff for about an hour and a half to discuss how you found the process and if it was useful or otherwise for you and the service user. This group will be repeated six months later. The groups will be audio-recorded and the recordings will be used as part of the analysis of the study. During the group you will be asked to talk about the mental health of the service users at your service how you see services’ role in recovery.

Is this study confidential?

Yes – Any information from the focus groups will be anonymised. Only the research team will have access to the audio-recordings of the focus groups and these recordings will be destroyed as soon as they have been transcribed. However, the usual rules apply and if information is revealed that suggests risk I may have to share this with relevant others. I have received ethical advice around the running of the project.

What will happen to the results of the study?

The study will hopefully be published in an academic journal. Again, it will all be anonymous. If you would like a copy of the final paper you are welcome to have one.

If you would like any other information feel free to contact Dr. Ken Murphy (lead researcher) at km270@canterbury.ac.uk at any time.

APPENDIX 6: SERVICE USER CONSENT FORM

CONSENT FORM FOR SERVICE USERS

PROJECT TITLE: What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices?

1. I CONFIRM THAT I HAVE READ AND UNDERSTAND THE INFORMATION SHEET FOR THE ABOVE STUDY. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

2. I UNDERSTAND THAT MY PARTICIPATION IS VOLUNTARY AND THAT I CAN WITHDRAW AT ANY TIME

3. I AGREE TO BE AUDIO-RECORDED DURING THE FOCUS GROUPS

4. I AGREE TO BEING QUOTED DURING THE STUDY AND I AM AWARE THAT QUOTES WILL BE ANONYMISED

5. I AGREE THAT THE LEAD RESEARCHER HAS PERMISSION TO OBTAIN LIMITED INFORMATION FROM MY CAREPLAN AND RECOVERY STAR NOTES THAT IS PERTINENT TO THE STUDY. THE NATURE OF THIS WILL BE OUTLINED TO ME AT THE BEGINNING OF THE STUDY.

Name of Participant

Date

Signature

APPENDIX 7: STAFF CONSENT FORM

CONSENT FORM FOR STAFF

PROJECT TITLE: What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices?

1. I CONFIRM THAT I HAVE READ AND UNDERSTAND THE INFORMATION SHEET FOR THE ABOVE STUDY. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS.

2. I UNDERSTAND THAT MY PARTICIPATION IS VOLUNTARY AND THAT I CAN WITHDRAW AT ANY TIME

3. I AGREE TO BE AUDIO-RECORDED DURING THE FOCUS GROUPS

4. I AGREE TO BEING QUOTED DURING THE STUDY AND I AM AWARE THAT QUOTES WILL BE ANONYMISED

Name of Participant

Date

Signature

APPENDIX 8: FOCUS GROUP SCHEDULES

FOCUS GROUP SCHEDULES – Service Users (Round 1)

INTRODUCTION

Hello. Thank you for taking the time to be here today. We plan to be here for an hour and a half and will take a break after 40 mins. The sessions will be recorded as per your information sheet. I hope this is ok with everyone? I am a trainee clinical psychologist and am doing a project on recovery in mental health. I have some questions for you today that will help my study. I will ask you some things about your mental health problems, the things that challenge you because of the problems and ways that help you. Please feel free to say whatever you wish. All information is confidential and we ask that what is said in the room stays in the room. The audio-recordings will be kept safe and only the research team will hear them. The study will result in a written report and also a feedback session to which some of you will be invited. Any questions before we start?

QUESTIONS

- What are the main problems you face due to your mental health problems?
Probe for: mental health problems, more practical problems (e.g. housing, money), recovery related themes.
- What are your main goals in life?
- What are the obstacles to your achieving these goals?
- How can your service help you with these?
- Can you tell me what you understand about recovery in mental health terms?
- What can your service do to help your recovery?
- What do you see as the role of staff at your service?

FOCUS GROUP SCHEDULES – Staff (Round 1)

INTRODUCTION

Hello. Thank you for taking the time to be here today. We plan to be here for an hour and a half and will take a break after 40 mins. The sessions will be recorded as per your information sheet. I hope this is ok with everyone? I am a trainee clinical psychologist and am doing a project on recovery in mental health. I have some questions for you today that will help my study. I will ask you some things about your service and your role in the service, the challenges you face and how you think your role helps service users. Please feel free to say whatever you wish. All information is confidential and we ask that what is said in the room stays in the room. The audio-recordings will be kept safe and only the research team will hear them. The study will result in a written report and also a feedback session to which some of you will be invited. Any questions before we start?

QUESTIONS

- What are the main problems service users face due to their mental health problems?
- What do you understand of recovery in mental health terms?
- What do you see as your role in the service?
- What goals do you think service users have in their lives?
- What are the obstacles to them achieving these goals?
- How do you think services can best help meet service user goals?
- What can/does your service do to help service users' recovery?

FOCUS GROUP SCHEDULES – Service Users (Round 2)

INTRODUCTION

Hello. Thank you for taking the time to be here today. We plan to be here for an hour and a half and will take a break after 40 mins. The sessions will be recorded as per your information sheet. I hope this is ok with everyone? I am a trainee clinical psychologist and am doing a project on recovery in mental health. You might remember me from the last time we met to discuss recovery. Some things have changed at your service in the last 6 months and I would like us to re-consider some of the questions we posed in the first group and also to think about the future. Please feel free to say whatever you wish. All information is confidential and we ask that what is said in the room stays in the room. The audio-recordings will be kept safe and only the research team will hear them. The study will result in a written report and also a feedback session to which some of you will be invited. Any questions before we start?

QUESTIONS

- What are the main problems you face due to your mental health problems? *Probe for: mental health problems, more practical problems (e.g. housing, money), recovery related themes.*
- What are your main goals in life?
- What are the obstacles to your achieving these goals?
- How can your service help you with these?
- Can you tell me what you understand about recovery in mental health terms?
- What can your service do to help your recovery?
- What do you see as the role of staff at your service?

FOCUS GROUP SCHEDULES – Staff (Round 2)

INTRODUCTION

Hello. Thank you for taking the time to be here today. We plan to be here for an hour and a half and will take a break after 40 mins. The sessions will be recorded as per your information sheet. I hope this is ok with everyone? I am a trainee clinical psychologist and am doing a project on recovery in mental health. You might remember me from the last time we met to discuss recovery. Some things have changed at your service in the last 6 months and I would like us to re-consider some of the questions we posed in the first group and also to think about the future. Please feel free to say whatever you wish. All information is confidential and we ask that what is said in the room stays in the room. The audio-recordings will be kept safe and only the research team will hear them. The study will result in a written report and also a feedback session to which some of you will be invited. Any questions before we start?

QUESTIONS

- What are the main problems service users face due to their mental health problems?
- What do you understand of recovery in mental health terms?
- What do you see as your role in the service?
- What goals do you think service users have in their lives?
- What are the obstacles to them achieving these goals?
- How do you think services can best help meet service user goals?
- What can/does your service do to help service users' recovery?

APPENDIX 9: TRANSCRIPT EXTRACTS

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APPENDIX 10: EXECUTIVE SUMMARY FOR REC AND R&D

PROJECT TITLE: What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices?

EXECUTIVE SUMMARY

Mental health policy initiatives have called for recovery-oriented practice to be the central emphasis for mental health services in the UK (New Horizons, 2009). However, the change from the traditional disease model, and the values and practices of services informed by it, has been problematic. There are many reasons for this including the difficulty of embracing change from a professional led, illness and symptom centred care to a client centred, strengths-based empowerment model (Slade, 2007). Some work has been done around how services can become more recovery-oriented, but implementation of these recommendations has been patchy. The current project aimed to begin a process of inquiry that will explore the discourses of service users and staff when their service adopts recovery-oriented practices which have the aim of enhancing their access to opportunities and offering them the supports they need to pursue meaningful lives, even within the confines of mental health problems. The project was guided by social positioning theory (Harre & van Langenhove, 1999) and used a Foucauldian Discourse Analysis of service user and staff focus groups. Recovery was variously constructed as clinical recovery, personal recovery, and ready for discharge. These constructions positioned service users as dependent, passive and hopeless or empowered and hopeful, and staff as helpless or supportive. It was also apparent that a discourse of personal recovery was not available to service users. Staff oscillated between the constructions of recovery as clinical and personal. The subject position of the service user and staff seemed to be context dependent and discourses of both service users and staff served to reproduce the mental health service as place where service users came to be fixed. Adopting a recovery orientation should lead to service users being positioned as more influential in decisions about their treatment and modes of support from the service, and services less likely to dictate their treatment. However, this can only happen if the recovery orientation constitutes a widely shared discourse with all its assumptions and associated practices. If it only involves some use of new words but keeping old ways of talking in key contexts such as CPA, real change will be hampered.

APPENDIX 11: EXECUTIVE SUMMARY LETTER TO REC

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Room xxxx X Floor xxxx,
Charing Cross Hospital,
Fulham Palace Road,
London W6 8RF

REC Ref: xxxxx

Dear REC Panel,

Please find enclosed a copy of the summary findings of my research project **What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices?**, which you approved on 19th April, 2011.

Thank you for reviewing the project and please feel free to disseminate the findings.

Yours sincerely,

Dr. Ken Murphy
Trainee Clinical Psychologist
Canterbury Christ Church University
Salomons
Broomhill Rd, Tunbridge Wells,
TN3 0TG

APPENDIX 12: EXECUTIVE SUMMARY LETTER TO R&D

XXXXXXXXXXXXX

XXXXXXXXXXXXX

XXXXXXXXXXXXXXXXX

XXXXXXXXXXXXX

RE: Executive Summary Research Findings; Dr. Ken Murphy (Trainee Clinical Psychologist)

Dear xxxxxx,

Please find enclosed a copy of the summary findings of my research project 'What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices?', which you approved on 28/4/2011.

The results should inform the introduction of recovery-oriented practices across the trust.

Thank you for reviewing the project and please feel free to disseminate the findings.

Yours sincerely,

Dr. Ken Murphy

Trainee Clinical Psychologist

Canterbury Christ Church University

Salomons

Broomhill Rd, Tunbridge Wells,

TN3 0TG

APPENDIX 13: ABRIDGED REFLECTIVE DIARY

Jan 2010: I think I'll do project on recovery. I know the area and would be good to keep up to date. I could approach xxx at the IOP. He knows a lot and might supervise me. But i also like xxxx. She was inspirational when lecturing and has an interest in recovery too. Mmhh...

Feb 2010: Meeting with Sue Holttum to discuss a recovery project. She seems like someone I would like to work with. She is on the research team and has an interest in service user issues. I think she is in SAGE too.

Mar 2010: xxxx and Sue have agreed to be supervisors. Sue will be the lead. Excellent.

July 2010: I am going to present my proposal at the SAGE meeting. A bit nervous to see if they will like it. I don't want to come across too professional and to feel like i am preaching to them. I probably need to reflect on this. Why am I anxious that they don't see me as a clinical psychologist (one of those bad professionals)? I am also aware that i need service user involvement in my research and so where is the power here? Am i using the group? I don't mean to and i value their input. Mmhh...

July 2010: got good feedback from SAGE. They made some suggestions around other told like the recovery star ut also liked the recovery star. It was developed by service users and i think they liked that. I did get the sense that they were a little anti-services.

September 2010: IRP proposal to sue to have a look aver before submission. i will do an action research project which is really exciting. Real change can only happen if service users lead the change. I need to develop a questionnaire.

September 2010: xxxx recruited a new senior psychologist with an interest in recovery. Great she will be a big help for me.

Oct 2010: had the salomons proposal review: it went well but he thought it was not really participatory action research and i should remove that. It will be a discourse analysis of focus groups. This is less ambitious but i guess it needs to be manageable. Maybe I won't change the world! Need to re-submit.

Dec 2010: got approval from salomons. Cool, can enjoy xmas at home.

Feb 2011: back in research mode. It's not been a priority for a while. Need to get my head back into it.

Feb 2011: sent my ethics form to sue. Its a long form and a pain to fill out. Lots of repetition. Seems like a big machine this NHS research business.

Mar 2011: I had the REC meeting in London today. It went well, as far as I can

determine. They questioned me for 10 minutes and seemed happy with my responses and said that they would send me a letter with a few minor points. I think that is positive?? I am meeting with the team on Wednesday and hopefully will get the focus groups planned for May.

May 2011: my mum has had to go into hospital for open heart surgery this week. The operation is on Monday. I haven't taken annual leave yet, but I may need to in the coming weeks. I am going to the recovery group today to try to recruit and set in dates for the focus groups. I may make these provisional dates given the circumstances. I'm really stressed out about mum but have to keep going here.

June 2011: mum has picked up an infection in hospital and her kidneys have failed. and me and my brother are advised to go home. It's not certain that she will survive. Research does not seem important now.

July 2011: mum is getting better so I am back at work and need to get recruiting for my MRP. That has set me back a couple of months. I hope it will all be ok.

July 2011: recruitment is taking longer than I expected. I need to get care co-ordinators to approach service users with the information and for service users to be interested enough to allow me to phone them. This is the ethical procedure. I need care co-ordinators to actually care about the research though. It feels like I'm not in control. That is difficult when there are deadlines to achieve and I might be behind already.

July 2011: I held the first staff focus group today. It was great to finally get started collecting data. It was a really good group with good discussion. My sense is that the staff would like to work in a recovery oriented way but that there are lots of systemic issues that get in the way. The main and most striking one is that service users are expected to be discharged after 2 years. This seems very 'service doing things to service users' which is not recovery oriented. Are they being asked to do the impossible?

August 2011: first service user group. This was the group with the guys from the recovery group. I attended the group before so they know me. Will this affect the discourses? Will this group be different to the ones for people using the recovery star? I had invited 6 people but only 3 came. It was a very rainy day. I will phone them and talk it through and can I invite them to the next one? I think so as I won't be comparing the groups, just looking for discourses at different time points and contexts.

August 2011: held the other focus group. Great round 1 complete. But to have a 6 month break I need to push round 2 until after xmas. I wanted my data by xmas, but I have to accept I won't have it. It will probably be fine.

I think the focus groups were good for the service users. It's not therapy but I think they got a lot out of it. It was worrying that they didn't really know what recovery was. They all think it's about getting back to where they were before their 'illness'. I think education around recovery is important.

There was a sense that people are afraid that if they 'recovery' they will have to leave services and they are scared of this. I think the message of 2 years in the recovery team is causing people to think that recovery = discharge. It also feels like people need help with the practical things in life.

Sep 2011: I am going to approach xxxx to consult on the project. It's a bit late in that I have already done round 1 but I think its still worth it.

Oct 2011: Good news. My paper has been accepted as an oral presentation at the international Refocus on Recovery conference in Kings College London. Nice one, but now I have to prepare that as well as everything else. It seemed like a good idea when I submitted the abstract! I really need to get the next groups done and get analyzing.

Nov 2011: im on a psychodynamic placement with people with psychosis. My supervisor has an interesting way to think about people with psychosis. She thinks there is a part of people that does not want to get better and recovery does not take this into account. She doesn't really like the recovery model. How will this influence me?

Dec 2011: gonna have the xxxx meeting in January.

Jan 2012: I sent an extract of the focus group with some initial coding to sue. She will look through it and give feedback soon. Transcription is going to take a long time. I need to factor that in. I could get it done externally but its expensive.

Jan 2012: this is a heavy MRP time. I need to get the second round of focus groups done. I need to get ready for the xxxxxmeeting and also think about the conference presentation in March. For that I need to have some analysis done. I should have done some of this before Christmas.

February 2012: I'm reading a lot about Foucauldian discourse analysis. It is complicated and different to any research I have done before. I am used to numbers, graphs and tables. This is not my language. I feel like a child. Maybe I should n't have done this. Is it too late to change? Yes.

February 2012: I'm getting my head around this analysis business. I'm glad of Carla Willigs method. At least there is some structure. Discursive constructions, subject positions, opportunities for action, subjectivity, and power. Mmhh, it actually makes some sense now. And I think it's a good way to look at my question. What subject position does talking about recovery in a particular way put service users and what effect does that have on their opportunities for action and how they feel. Is the service an oppressive institution. I'm starting to like reading about Foucault too and sue has given me some good papers. I need to be mindful of the effect of my psychodynamic placement on my interpretations. Interesting word to have just used!

March 2012: This transcription is boring and taking up too much of my time. I should get it doe professionally. Then I could focus on everything else. It feels like its all coming to a head now. I will be presenting preliminary results at the conference. I

need to get sue to look at my transcripts. She is giving really helpful feedback. I would be lost without her.

March 2012: The presentation went really well. I got a lot of questions and there was a queue of people to talk to me after! Most of the feedback was good but I did get some people that were anxious about services taking over this idea of recovery and of service

users getting recovery done to them. Also a guy from recovery Devon did not like the term service user and thought that I should think about the language I use also - though he said he agreed with what I was saying and that language and discourse are very important.

The conference itself was very good, though I did get a sense that services are really grappling with how recovery fits for them and that it is very variably incorporated. Also I still think that a lot of people, even researchers, are using the term in the way the people in our groups are using it, and this reflects the wider medical discourse. I think our method is a really good way of getting at this difficulty. I need to do more analysis and have more examples from my transcripts that capture this.

xxxxx gave a very controversial and critical plenary about recovery. he said that he did not like the word and did not believe in recovery, and was very worried about it being used cynically politically to move people through the system and into jobs, no matter what the job. Once the service user is doing ok they will be discharged. If they remain in the system too long they are seen as scroungers. Associated with shortening of the length of time are expected to be in services. This seemed to fit with my results so far.

xxxx group gave a good session on his refocus model intervention. This is an RCT in which he wants to show the efficacy working in a recovery oriented way. His aim is for this model to be in the NICE guidelines for schizophrenia next time round.

April 2012: I got a draft of my section A. it was hard work. It's a weird task. It's not an introduction and not a critical review, but its kind of both. Anyway I hope it's ok. Doing lots of analysis now. Its coming together I think. There are some definite discourses that I can see. They are definitely having an effect on service users and staff too so I think there will be something to write about. Thank god!

May 2012: spending a lot of time at research these days. Coding, analyzing, reflecting, changing ideas, thinking about wider social discourses beyond the project. How do these discourse effect all of us in our everyday lives? Who says it's a good idea to spend 50 hours a week working. That's is a taken for granted discourse – the work ethic. Maybe I don't have to do this. Or is that a defense? Mmhh,

May 2012: got feedback on section A. seems ok. I think I will get that I shape pretty quickly. Great. Section B is more difficult. Writing up qualitative is challenging for me. It does not feel natural, but im getting more used to it.

June 2012: I need to submit the whole thing next month. I cant believe it. I think it will be ok but I still feel like I have a lot to do. Sec A is ok sec B needs to be finalized and sent to sue. I have been thinking about sec C as I go so that should be ok. I have a lot of appendices. Need to get them in shape.

July 2012: I will submit in 3 weeks. I can't believe it. It feels ok. I'm surprised I'm not more freaked out. Its not finished yet though!

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APPENDIX 14: RECOVERY STAR AND NOTES

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APPENDIX 15: CAREPLAN EXTRACTS

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APPENDIX 16: JOURNAL OF MENTAL HEALTH GUIDANCE FOR AUTHORS

Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

Submissions

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at <http://mc.manuscriptcentral.com/cjmh>. New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the

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article's intellectual or technical content.

Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice.

Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association , and all references listed must

be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

- a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18 , 351–355.

- b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management* . London: Routledge

- c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered

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where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Accepted papers

If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00/\$25.00 per copy. Copyright. It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Informa Healthcare. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms. Authors may, of course, use their article and abstract elsewhere after publication providing that prior permission is obtained from Taylor and Francis Ltd. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.

APPENDIX 17: RECOVERY CONFERENCE KING'S COLLEGE LONDON 2012

WHAT KINDS OF DISCOURSES ARE SERVICE USERS AND STAFF DRAWING ON DURING THE ADOPTION OF RECOVERY-ORIENTED PRACTICES?

Ken Murphy, Sue Holttum & XXX
Salomons, Canterbury Christ Church University & XXX
NHS Foundation Trust

REFOCUS ON RECOVERY, KINGS COLLEGE LONDON, 2012

PRACTICE GUIDELINES

The REFOCUS Model (2011), Promoting Recovery in Community Mental Health Services, Rethink and REFOCUS Group.

- Aims to promote social recovery via:
1. Recovery-Promoting Relationships
 2. Working Practices
 - Understanding values and treatment preferences
 - Assessing Strengths
 - Supporting Goal Striving

WHAT IS A DISCOURSE?

A network of connected ideas, shared between many people around us, which tells us:

- a) How to think about a certain aspect of the world,
- b) What should happen in certain social contexts related to this aspect, and
- c) How the people who interact in certain situations are expected to behave, e.g. who can talk, who has most influence on outcomes, etc.

POLICY INITIATIVES

- Recovery orientation was adopted as the overarching model of care for mental health services by the U.S. Surgeon General in 1999.
- Recovery should be the 'guiding light' for mental health services in UK (New Horizons, 2009)
- XXXX re-organised community services to create Support and Recovery Teams in 2009/10

OVERVIEW OF THE CURRENT STUDY

- **What discourses are service users and staff using when a service introduces recovery-oriented practices?**
 - Newly formed Support and Recovery Team in XXXX
 - Six Focus groups of service users and staff (three at early stages and three 6 months later)
 - Foucauldian Discourse Analysis
 - Feedback and intervention

DA CONTD.

- **Taken-for-granted ideas:** An important aspect of these discourses is that they entail 'taken-for-granted' ideas.
- **Questioning the taken-for-granted:** DA researchers specialise in highlighting the 'taken-for-granted' so that it is easier to see and can be questioned.

DISCOURSE ANALYSIS

- Qualitative research that is constructionist focuses on how people talk and write about the world, rather than how the world really is.
- **Discourse analysis (DA) researchers look at what kinds of discourses people use:** Instead of looking for the things that service users thought were most helpful, you might look at the kind of words that service users and staff use in talking about the service – e.g.
 - Was there talk about treatment and correcting imbalances in people’s brains (medical discourse);
 - Was there talk about supporting people to move towards goals they have decided for themselves such as learning a new skill or getting a job (recovery discourse).
- **Here we are not interested in which of these is most helpful.** We are interested in how people talk (discourses they use) about a mental health service as a social institution – what kind of institution is it?

HOW ARE SERVICE USERS’ PROBLEMS CONSTRUCTED?

- Mental Illness still talked about as a disease like any other - SU and staff still talking about ‘recovery from’. Discourse of medical condition and cure persists.
- e.g. ‘Recovery is being 100% better’ - Service user*
‘There is no difference between me and you and someone with diabetes’ – Staff
‘They have found the right drug now. It takes time’ – service user
- This medical discourse positions SU in the patient role with staff/doctors in powerful position and SU as not expected to question decisions and being passive recipients of care. Being in this position does not allow opportunities for action – to pursue personally meaningful goals, leaving SU hopeless and powerless.

HOW ARE STAFF ROLES AND TASKS CONSTRUCTED?

- Recovery constructed as both ‘clinical’ and ‘personal’ recovery (Stade, 2009).**
- When recovery is seen as ‘clinical recovery’ the staff are often hopeless
- E.g. ‘We may have to accept that some will never recover’.*
‘We can help them to manage but it is there for life’ - staff
‘I want to get back to the way I was’ – service user
- This positions the SU situation as hopeless and some are ‘too ill to help’, not giving them any reason to act/ strive for goals, and leaving them feeling powerless.
 - Fixed mindset
 - Here the mental health service can become an oppressive institution that disempowers service users. This may not happen at a conscious level, but is the result of the assumption that services should be ‘making people better.’

RESEARCH QUESTIONS

- what discourses are drawn upon to describe change or non-change in and by service users?
- what discourses are drawn upon to describe change or non-change in and by the service/staff?

MEDICAL DISCOURSE CONTD.

- Legitimises mental illness as biological, and so it is not questioned. Here we can highlight the ‘taken-for-granted’ notion that there is such a thing as mental illness like any other illness that is a disease of the brain and it can be treated by pills that fix chemical imbalances.
- This medical discourse directly hampers the adoption of recovery discourse as it constantly reconstructs service users as passive recipients and staff as carers rather than facilitators of personal goals and aspirations.

- **When recovery is seen as SU being ‘in recovery’ creating a personal recovery discourse staff are more hopeful**

E.g. ‘its about social inclusion.. And getting people part of the community’ – staff (bridge-builder)
‘The social worker ... helps with goals in my life’ – SU

- This positions SU as being capable of being able to achieve goals in the community, making possibilities available to them, opening opportunities for action, and potentially leaving them with a feeling of achievement of personally meaningful goals.

So when a discourse of personal recovery is used over clinical recovery possibilities and potential is opened up. Different discourse/ talk as creating different meaning/possibilities.

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HOW IS CHANGE OR NON-CHANGE IN AND BY THE SERVICE/STAFF CONSTRUCTED?

Positive Change – potential for change

e.g. *'We could have CPAs in the GP surgery... to keep links with people... After they are discharged'* - staff
'something like the recovery star could be used in CPAs'
– Staff

- This discourse positions SU as more involved in decision making, opening up opportunities to achieve personally meaningful goals by influencing team decisions and thus making them feel a sense of empowerment, achievement and hope.

○ Implications of moving to a 'personal recovery' orientation

"Adopting a recovery orientation should lead to service users being positioned as more influential in decisions about their treatment and modes of support from the service, and services less likely to dictate their treatment. However, this can only happen if the recovery orientation constitutes a widely shared discourse with all its assumptions and associated practices. If it only involves some use of new words but keeping old ways of talking in key contexts such as CPA, real change will be hampered." (Holtum, 2012)

Negative Change

- "Recovery/Empowerment" associated with discharge and abandonment and service cuts

e.g. *'changes took place and I know several of my friends felt.. um.. frightened'* - service user

'we have a target that people will be in our service for two years' - staff

'The idea of services being taken away and being suggested that you form self help groups' - service user

- This discourse positions service users as being abandoned by services. Recovery is associated with discharge and constructed as too much responsibility for SU, closing opportunity to avail of services, leaving them feeling fragile and isolated.