Recovery Conversation

Report of a consultation event on the future promotion of mental health recovery in Scotland

Summary report informed by Matthew Haggis (Creative Exchange), Scottish Recovery Network & Scottish Government
Introduction

This report summarises the views of participants at a half day event on December 3rd 2014, which was convened jointly by the Scottish Recovery Network and the Scottish Government’s Mental Health and Protection of Rights Division. The agreed purpose of the event was ‘to hold an open conversation about the future development of recovery approaches to mental health in Scotland.’

The event objectives were to:

- Bring together recovery stakeholders from across Scotland for half a day of facilitated discussion.
- Enable discussion of progress made and challenges experienced in the promotion of mental health recovery in Scotland.
- Inform and reinvigorate the future development of recovery approaches in Scotland.

The 51 delegates who attended on the day were invited by the organisers with a view to ensuring a good representation across relevant stakeholder and interest groups.

Following a welcome by Penny Curtis, Acting Head of the Scottish Government’s Mental Health and Protection of Rights Division the conversations were structured around three key questions proposed in a Briefing Paper which had been circulated in advance. Each question represented a theme and was underpinned by a set of supplementary questions. In the context of each overarching question, delegates were asked to consider the experience to date and to discuss implications for recovery moving forward.

This report highlights key themes, issues and ideas discussed by participants. A large amount of detailed and pertinent information was exchanged and this summary does not attempt to record this in full. Notes from each round table discussion have, though, been retained for inclusion in future development planning.
Question 1: Is recovery too individualistic and overly prescribed?

Experiences to date

NO! Recovery has to be focussed on the individual and delivered, never prescribed.

Recovery as an overarching approach is often not what individuals meet in practice. Choices and expectations are limited by what’s on offer as opposed to what’s needed.

There have been important shifts in language. But there are still questions about this too – does ‘recovery’ place pressures on people? What happens when we call something ‘recovery’? How does ‘recovery’ relate to ‘feeling well’? Can I get too well? Why is it still so medicalised?

Living well may or may not mean having a relationship with services, or a reduction in the use of services. The process of recovery can mean the risk of ‘being moved on’.

People also experience recovery out with their use of services, making choices in their community to bridge gaps. There has been positive input from practitioners, and open conversations, which have facilitated change.

The challenge of joined-up thinking is with us – how do welfare reforms support recovery practice and values?

Recovery happens in an environment of stretched resources and low staff morale. Staff in services who find themselves ‘firefighting’ struggle to apply the principles of recovery.

SRI 2, when made meaningful to the person, can lead to reflective conversations, highlight the cycle of change, and help keep everyone on the same page. Recovery conversations are often courageous conversations.

Moving forward

What about citizenship and recovery? Make active citizenship a goal or process for people in recovery. Recovery should be about basic ‘grass roots’ rights, not something services choose to do.

Stay aware of the perception of ‘risk’ or ‘threat’, and the misuse of the recovery word.

Importance of reflection, keeping core values at the heart and making time to truly listen

Aim for truly compassionate services, and compassion between services. And practice compassionate speech – to ourselves, to others, with others. But don’t try to ‘prescribe’ compassion.

Beware the primacy of the medical discourse getting in the way. What is the right way of doing things? Is it what is meaningful to communities? Are we measuring and valuing the softer outcomes in our targets?

Use WRAP and other tools to encourage opportunities for discussion, and to encourage holistic thinking. SRI2 supports reflection, ownership and involvement.

Where there is a focus on challenge, we need to protect people too.

Focus on self development. Recognise the healing in relationships. Actively involve teams in self development.

Build on the strong relationship between SRN and see me.

Ensure people bring authenticity, as some things can’t be taught – peer support is important, although some may fear the challenge of introducing it.

Often it is peer workers who say the ‘honest things’. And natural networks around people are important to success. Can we provide the structures which allow people to share?

Acknowledge recovery as a journey.
**Question 2: Is recovery one way for mental health services or the way?**

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<tr>
<th>Experiences to date</th>
<th>Moving forward</th>
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<tr>
<td>Definitions and the use of language are important. Recovery is not a model, is not prescriptive. It is about moving beyond clinical symptoms, about person-centred conversations, about enabling reflections on broad themes. Recovery is a journey and must support all stages of the journey, not just the crises.</td>
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<td>Keep going back to revisit what recovery means, and how the term is being used. It bridges from the personal and the individual through to the structures and strategies of the NHS, so is always being reinterpreted.</td>
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<td>Recovery will only ever be one way while there are power dynamics pulling in other directions, notably psychiatry and the medicalised paradigms of diagnosis and treatment. Where power affects practice, there will be feelings of threat, risk and vulnerability.</td>
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<td>Make the most of the workforce by embedding good mental health, enabling the use of human, lived experience, and having open, honest conversations in a spirit of mutual partnership.</td>
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<td>Concern that recovery being ‘the way’ would lead to being prescriptive about what it is and what it is not, and to limiting judgements. Also real concerns about recovery linked to assessments, and to cuts in services, benefits and support.</td>
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<td>Ensure Government is clear with its direction and new ways of working, and is explicit about policy priorities – e.g. recovery and SDS.</td>
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<td>We need to talk about reconciling recovery with compulsion, or risk creating or sustaining differences in practice.</td>
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<td>Make full use of peer support, brokerage, community focus etc. by building value and supporting people and organisations to work together.</td>
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<td>Things still seem so patchy. Are we learning from what is going well, what individuals are doing?</td>
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<td>If power is the ‘elephant in the room’ for recovery approaches, we have big issues including: pharmaceutical power and societal belief in the pill to cure; hospitals provoking strong emotions. We need to hold people to account and think about how do we best influence power of legislation? Can practice be used to affect power?</td>
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<td>Recovery is an attitude and a bag of many tools, not a prescribed way of working. If it offers hope and light at the end of the tunnel, recovery must be the way!</td>
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<td>There is still a need for more training of professionals.</td>
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<td>Build consensus – avoid blame cultures. Them-and-us, polarisation is not helpful. We can build on the goodwill out there.</td>
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<td>What conversations and dialogues are we having and questions are we asking? Have honest conversations with ourselves and the public.</td>
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<td>Use our knowledge of change management.</td>
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Question 3: Is there a recovery credibility gap?

Experiences to date

Recovery as a conversation has changed some things, but has it just been tinkering? What about a simple sentence for common understanding – “Recovery is…”? But it probably can’t ever be one thing for everyone. “It’s my right to define my own recovery!”

Recovery is an up and down journey, which can include crisis, that includes housing and social needs. Services need to see the whole person and look at their context, not just look at the individual service need.

Recovery has become associated with pressure to discharge.

The gap for people using services remains because they don’t experience the policy in practical services they use. But the solution is not to rebrand or dismiss the term ‘recovery’. The gap appears when services use the language but don’t do it. Also for people who are not recovering.

If the main issue is feeling safe and well, recovery is about community resources, not just statutory services. Recovery works when services don’t look like services.

The credibility gap amongst professionals remains because recovery is not evidenced by RCTs.

Is there a shared understanding of the meaning of the term ‘recovery’? Difficulties in understanding can lead to difficulties of acceptance. The conversation it is more important than the term. It’s a useful term and concept which has not yet outlived its usefulness. It can help in other discussions (e.g. assets, person-centred) and now needs to move outside mental health. We need to recognise and embrace the gaps, and not let them become too corrosive.

Moving forward

The use and power of language is important. Is ‘recovering’ more attainable than ‘recovery’? Terms like ‘referred’, ‘assessed’ and ‘diagnostic approaches’ may not be the best way of helping. Has power shifted away from the person through the subtle use of language?

We will have moved forward when services have caught up with the idea of more flexibility and individual response. Less about ‘admitted’ and ‘discharged’ and more about the fluctuating need.

What works? We need to point to success, and the evidence. There are types of evidence, types of audience, types of approach. Even small changes can create evidence that can be demonstrated.

We need to help people realise and use their own expert knowledge. An explicit invitation to bring expert knowledge, and a vocabulary for people to articulate it.

Identify the conditions that help recovery work, and learn the lessons from others, such as GIRFEC and dementia: Charter of Rights.

There is an opportunity for mental health to lead the way in integration, given the experience and expertise. But we need to do it now, while integration is ‘hot.’

Is it better or worse being linked to other initiatives such as SDS, disability, drugs/alcohol etc?
Final Plenary

Following round table discussions there was a whole group plenary session where a number of contributions were made. People described finding the discussions to be timely and the process on the day to be exciting and inspiring. One participant questioned whether we should be asking these questions of recovery approaches when we might more usefully ask questions of the dominant ‘medical model’. Other feedback could be loosely themed under two headings as follows:

Policy and practice

- There is learning to be had from other policy driven approaches like the Dementia Strategy and Getting it Right for Every Child (GIRFEC).
- We should also be looking to integrate recovery approaches more fully with wider policies and making the connections for people.
- In Self Directed Support they are using the language and policy of recovery but not following that through in implementation. We can influence and inform that.
- We need help from the Government and those at the top to bring change about.
- See the Christie report recommendations and apply these in alliance with recovery.

The way ahead

- A weariness can develop, so we need to think about how we sustain recovery champions and leaders.
- We can work towards developing ‘recovery communities’ in which we all support each other regardless of our experiences.
- Recovery could be promoted in more of a campaign type way, for example, similar to the way that Power of Attorney has been recently promoted.
- If the first ten years have been recovery in services then the next ten must be about recovery and citizenship.

Niall Kearney, Head of the Scottish Government’s Mental Health Improvement Unit, closed the session by thanking delegates and describing his enthusiasm for the future development of recovery approaches. Within this message he emphasized the change that has already been realized, while acknowledging there is a long way to go. To continue this process he suggested a focus on the radical message of recovery.

What we take from this and next steps

This event was one part of the ongoing efforts of SRN and the Scottish Government to ensure that efforts continue to be informed by the experiences and views of people affected by mental health issues and those supporting them. We welcome hearing increasingly diverse views on recovery and its application in policy and practice and feel reassured that it has lost none of its early dynamism as a subject which has the potential to both enervate and frustrate.

While it was a relatively small gathering of people, there was a good range of representation and we took encouragement from these discussions that there remains a major role for recovery to play in informing and improving our efforts locally and nationally to improve outcomes. At the same time we are very aware that there are real challenges to further progressing the promotion and support of recovery.

We noted a strong desire from those present to re-emphasise and revisit the founding principles and values of recovery to help address its potential for misinterpretation and misappropriation of the term. Delegates emphasised the role of the use of recovery focused language within this. There was some consensus that while recovery had been highly influential in the last ten years there was still a long way to go before we could claim to have a consistently recovery oriented mental health system. It is interesting to note that some delegates described the potential to more fully align the promotion of recovery with a citizenship agenda and one which is potentially less concerned with the development of mental health services.
Notwithstanding that, practical suggestions were made as to how recovery could be further aligned to, and informed by, wider policy agendas, including Health and Social Care Integration.

This report will be taken into consideration by Scottish Government in the development of the future direction of mental health in Scotland. The discussions also importantly mark the start of a process to inform the next Scottish Recovery Network Strategic Plan.
Appendix 1: Participants

Donna Barrowman, Hope Café
John Beaton, HUG
Joan Blackwood, NHS GG&C
Simon Bradstreet, SRN
Trish Burnett, Carr Gomm
Jim Campbell
Louise Christie, SRN
Anne Connor, Outside the Box Dev. Support
Brian Crozier, ENeRGI
Penny Curtis, Scottish Government
James Dalrymple, Partnerships in Care
Duncan Davidson, NHS Tayside
Gillian Davies, NHS Highland
Elinor Dowson
Audrey Forrest, ACUMEN
Susanne Forrest, NES
Jan Gaffney
Beth Hamilton, Scottish Government
David Harrison, VOX
Nigel Henderson, Penumbra
Linda Irvine, NHS Lothian
Niall Kearney, Scottish Government
James Kennedy, Stracathro Hospital
Mark Kinghorn
Wendy Laing, ENeRGI
Fiona MacDonald, CAPS

Wendy McAuslan, VoX
Marie McCaig, University of West of Scotland
John McCormack, SRN
Shona McIntosh, Scottish Government
Colin McKay, Mental Welfare Commission
Dennis McLafferty, North Lanarkshire Council
Graeme Mollon, City of Edinburgh Council
John Moody, SRN
Debbie Mountain, NHS Lothian
Lucy Mulvagh, SRN
Lorraine Nicholson
Kevin O’Neill, NHS Lanarkshire
Chris O’Sullivan, Mental Health Foundation
Sara Redmond, Alliance
Amanda Scott, City of Edinburgh Council
Susan Scott, Plus Perth
David Smith, ENeRGI
Lesley Smith, SRN
Robert Stevenson, SRN
Gary Tanner, NHS Lanarkshire
Karen Taylor, Working to Recovery
Heidi Tweedie
Usman Waheed, Support in Mind
Theresa Watson, NHS Lanarkshire
Heather Williams, NHS Health Scotland