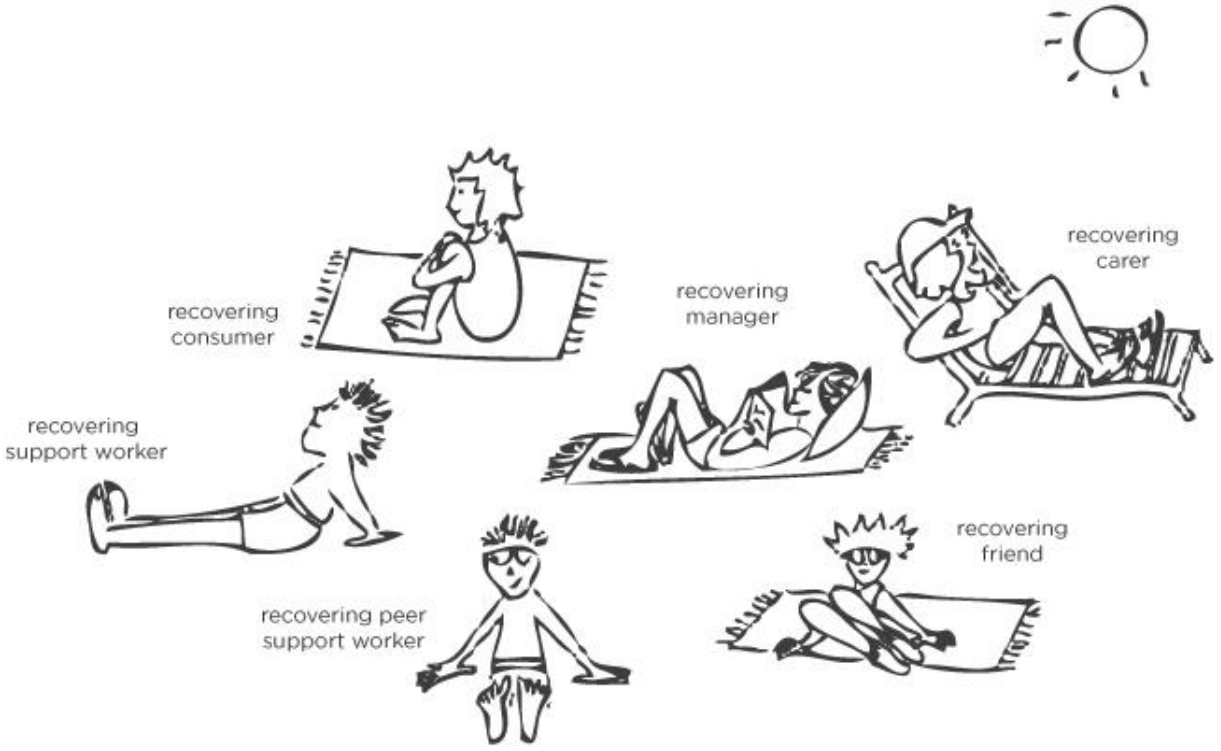
ROSSAT

Recovery
Oriented
Service
Self-Assessment
Toolkit



ROSSAT Implementation Project: Literature Review

A Recovery Oriented Service Provision
Quality Improvement Resource for
Mental Health Services

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The cartoons used on the front cover of this document have been adapted with permission from '*Recovery'* by Merinda Epstein, Coordinator *Our Consumer Place Victoria*. Source: http://www.takver.com/epstein/cartoon095.htm

Contents

1. Introduction

"I was diagnosed with bipolar 2 and ADHD in 2006. I was 24 then. After going through an extreme manic episode, I knew I needed help. And fast. When I look back on the years preceding my diagnosis, there were big warning signs I wasn't well. From the age of 16, my head suddenly began to operate independently of what I wanted it to do. I now understand that was bipolar. Back then I thought it was normal.

So I began to self-medicate. A treatment plan I devised myself; so dangerous to someone with mental health issues. Over the next eight years, I struggled with alcohol and drug use. I couldn't just drink a few drinks. I had to wipe myself out. For that was my intention always. I didn't want to feel the hurt from depression and I wanted to numb the confusion and anxiety of hypomania. The comedowns were horrifying but that brief moment of escape made it seem worthwhile. Until I kept going down, down, down.

I'm now on an extensive treatment plan that includes medication, therapy, being mindful and working with my amazing husband, family and friends. I have two degrees, about to start my Masters, a great job and am leading a life I'm proud of. I've found that doing the things I love helps greatly. For me that includes writing, reading, study, sport and music. I still have my down days, my up days and my all over the shop days. But doing the things I love regularly keeps me excited, engaged, and looking to the future.

I have to confront my mental illness by managing it every day. It doesn't own me. I can own it. I no longer just want to survive. I want to thrive. I choose happiness. I choose health. I choose life"

- Consumer story on the Mental Health Commission website

1.1 The Recovery Oriented Service Self Assessment Toolkit

In 2009 and 2010, the NSW Consumer Advisory Group (CAG) in collaboration with the Mental Health Coordinating Council (MHCC) established a project with the aim of developing a resource to assist mental health Community Managed Organisations in delivering recovery oriented services.

The NSW Ministry for Health Infrastructure Grant Project funded Stage One of the ROSSAT Project which comprised of the following activities:

1. A literature review
2. Consultations with consumers, families and carers and mental health service providers

3. Development of the ROSSAT Tool for Organisations (T4O) and Tool for Workers (T4W)
4. Cross referencing the ROSSAT T4O with the *National Standards for Mental Health Services*
5. Trialing the ROSSAT within four mental health services.

Specifically, the ROSSAT assists organisations and staff to:

1. Assess their level of recovery oriented service provision;
2. Reflect on individual practice and organisational systems and processes in relation to recovery oriented service provision; and
3. Identify and develop a plan to work on areas requiring improvement.

Six domains emerged from the literature review and consultation and became the Key Indicator Areas in the ROSSAT, including:

1. Relationships
2. Respectful practice
3. Consumer self-directed focus
4. Belief in consumers recovery
5. Obtaining and sharing knowledge and information, and
6. Participation and social inclusion.

See *Section 4. Conclusion* for the definitions of the above constructs.

1.2 The initial literature review (2009)

The literature review conducted in 2009 covered the historical background to recovery, definitions, concepts and facilitators of recovery, barriers to recovery oriented practice, principles of recovery oriented practice and what needs to occur to embed recovery oriented practice in a service or program (see http://www.mhcc.org.au/media/2498/nsw-cag-mhcc-project-recovery-literature-review.pdf).

In summary, the literature in 2009 identified that the origins of the recovery movement can be traced to the human and civil rights movements in the United States in the 1970s and 1980s, and that there is both empirical and narrative evidence that people living with mental illness can recover. Much of the literature until 2009 draws on individual narratives, which highlight the complexity of defining recovery due to a diversity of experience.

It was identified that what it means to 'recover' can be viewed from two different perspectives:

- The clinical view of recovery: recovery is a return to a former state of health or "cure". Clinical recovery outcomes include medication use and reduced hospitalisation and symptomology.
- The personal view of recovery: recovery is driven by people's individual experiences of mental distress and recovery. Personal recovery outcomes include empowerment, hope, choice, self-defined goals, healing, wellbeing and control of symptoms.

Overall, the 2009 literature review indicated that recovery includes:

- The ability to live a meaningful life
- Redefining a positive sense of identity
- Making certain life adjustments
- Overcoming symptoms, stigma and discrimination, and
- Living with hopefulness for the future.

However, despite these consistencies, it was also found that there is no one definition of recovery, and that a balance must be found between creating a concrete concept to guide services in practice, and ensuring the ability for consumers to define their own concept of recovery according to what is meaningful and useful to them.

Concepts and facilitators of recovery include taking control of one's life through individual responsibility, acceptance of illness, hope for the future, identity and empowerment, and advocacy. Other key concepts important to recovery include understanding one's illness, medication and symptoms; developing a healthy lifestyle; having supportive relationships; nurturing one's whole self and spirituality; and social inclusion in the community, including access to education and training, employment, and accommodation. Barriers to recovery and recovery oriented practice were identified at the individual, group, worker and systems levels.

A couple of recovery models were identified including the Wellness Recovery Action Plan (WRAP), the Strengths Model and the Tidal Model. In addition, tools for staff and mental health workers to use to enhance recovery oriented service provision were identified including the Collaborative Recovery Model, Australian Mental Health Work Qualifications and Training, and Recovery Self-Assessment (RSA).

1.3 The current project

This Stage Two project was funded by the NSW Ministry of Health. This literature review is the first component of the Stage Two project to identify emerging knowledge on recovery and recovery oriented practice since the initial literature review (2009 onwards). The review aims to answer the following questions:

1. What new literature exists on recovery since 2009?
2. What new literature exists on recovery oriented practice since 2009?

2. Method

The method for approaching the literature searches included:

1. Journal database searches
2. Manual inspection of frequently appearing articles and review reference lists
3. Google search engine and Google Scholar
4. More informal means such as advice from Reference Group members.

A search was conducted with databases and keywords as follows:

- Databases: CINAHL, EMBASE, Informit e-library Health / and Humanities & Social Science collections, MEDLINE, PubMed, PsycInfo, Proquest Social Science Journals
- Keywords: ‘recovery’, ‘recovery-orient*’, ‘practice’, ‘implement*’, ‘measur*’, ‘support*’, individually and in combination.

Titles and abstracts were read and those papers explicitly referring to recovery and recovery oriented practice published in 2009 onwards were saved. Full articles were then read against exclusion criteria including:

- Written in language other than English
- Commentary, opinion piece, book review
- The paper was not referring to personal/subjective recovery but to clinical recovery.

The purpose of this review was to find a breadth of research on recovery and recovery oriented practice and thus was not limited to specific areas of interest. However, it is not suggested that the literature identified is exhaustive.

3. Results

3.1 Understanding recovery

SUMMARY

Overall, the literature on recovery since 2009 includes more evidence to support the reality of recovery from mental illness. There are many different ways of understanding recovery according to a range of different perspectives, and so the literature emphasises that recovery 'belongs' to each individual and that the concept of recovery must stay linked to human rights. It is important to take a holistic approach that features the consumer perspective and their interpretation of their own experience.

Since 2009, there has been a growing evidence base including the development of the first overall conceptual framework of personal recovery which includes four main characteristics: Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment.

An overall model of the stages of recovery has also been developed, including a journey from Pre-contemplation to Contemplation, Preparation, Action and Maintenance and growth. A common continuum between stages of recovery can be seen across models in the literature, from passivity and feeling overwhelmed to having a sense of control and taking action. Evidence supports the concept that recovery involves a movement towards a more meaningful and positive identiy, and that the later stages of recovery involve acceptance, control, self-love and optimism, pleasure, meaningful activity, and positive relationships.

The literature continues to highlight the differences between clinical and personal recovery. The clinical concept of recovery is attached to illness, while personal recovery is attached to social and personal change, self-determination, participation and hope. Evidence suggests that clinical measures do not assess personal recovery, and that clinical recovery or symptom reduction is not necessarily a requirement for personal recovery.

Further support has been provided for a number of critical factors to recovery including the importance of:

- Dignity of risk
- Community participation
- Meaning and hope; and
- Relationships supporting recovery.

The most prominent definition of recovery identified in the 2009 Literature Review remains the most commonly cited and broadly accepted one:

> *"Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (*Anthony 1993, p.13).

Similarly, the literature continues to identify the complexity of the concept of recovery, with many meanings created by a diversity of stakeholders including consumers, carers and families, service providers, researchers, policy makers, politicians and the general public[1]**.** As such, developing a shared understanding of what recovery means remains problematic, and there is still no consensus around how many stages of recovery there are and what comprises the recovery journey[2].

However, while there is no one shared definition of recovery, this diversity of knowledge and experience provides an opportunity to reflect comprehensively on what recovery is[3]. More recent research is broadening the conceptualisation of recovery as a multi-dimensional and multi-staged process, pointing to the importance of adopting a holistic understanding of recovery with multiple underpinning constructs[4]**.** Further, despite individual differences, a number of common themes continue to emerge, for example recovery is:

- A process
- Best guided by the person with lived experience of mental illness
- Does not always involve 'treatment' or 'intervention' provided by service providers
- Does not always involve a reduction in symptoms
- A shift from seeing a consumer as a patient to a person with expertise.[5]

Ultimately, the complexity of recovery is managed through the recognition that recovery "belongs" to each individual person and that the definition, conceptualisation and operationalisation of

[1] Davidson et al. (2010); Ramon (2011)

[2] Weeks et al. in Hancock et al. (2013)

[3] Gordon and Ellis (2012)

[4] Hancock et al. (2013)

[5] Slade (2010)

recovery must remain consistent with the human rights movement from which the concept originated[6].

Since 2009, there has been a shift from ideology and narrative evidence to empirical and systematic studies and an increase in practical manuals and guides[7]. For example, Slade et al. (2012) conducted a review of empirical studies to highlight existing evidence in support of a number of ideological statements associated with recovery including:

- Recovery is a process not an outcome;
- Recovery begins when you find someone or something to relate to;
- Hope is necessary for recovery;
- Mental health workers can help or hinder recovery; and
- Recovery can be scientifically investigated[8].

More recent studies have also added to the evidence supporting the reality of recovery from mental illness. Warner (2010) conducted a review and found that optimism about recovery from schizophrenia is supported by research, as is the importance of empowerment and the opportunity to work for the recovery process.

Miller at al. (2010) investigated patterns of recovery from severe mental illness in a model integrated service delivery system (n=658) using the Milestones of Recovery Scale (MORS), (extreme risk; unengaged, poorly self-coordinating; engaged, poorly self-coordinating; coping and rehabilitating; early recovery; and self-reliant). This study provides the first insight into the recovery trajectory according to months of care and current recovery level. The findings suggest that only 8% of consumers stay in the 'extreme risk' category after 12 months, and after 2 years just under 50% of consumers in an 'extreme risk' category progress to 'coping/rehabilitating', 'early recovery' or 'self-reliant'.

Based on their systematic review of personal recovery (n=97 articles) Leamy et al. (2011) developed the first empirically based conceptual framework that includes 13 characteristics of the recovery journey and five recovery processes (See Table 1). This framework is a significant development for advancing understanding of and clarifying what recovery means.

[6] Davidson et al. (2010); Slade (2010)

[7] (Slade et al. 2012a); Slade et al. (2012b)

[8] Slade et al. (2012b)

Table 1. Conceptual Framework of Personal Recovery – characteristics and processes

Recovery characteristics	**Recovery processes (CHIME)**
• Recovery is an active process • Individual and unique process • Non-linear process • Recovery as a journey • Recovery as stages or phases • Recovery as struggle • Multidimensional process • Recovery is a gradual process • Recovery as a life-changing experience • Recovery without cure • Recovery is aided by supportive and healing environment • Recovery can occur without professional intervention • Trial and error process	*Connectedness* • Peer support and support groups, Relationships • Support from others, Being part of the community. *Hope and optimism about the future* • Belief in possibility of recovery, Motivation to change, Hope-inspiring relationships, Positive thinking and valuing success, Having dreams and aspirations. *Identity* • Dimensions of identity, Rebuilding/redefining positive sense of identity, Overcoming stigma. *Meaning in Life* • Meaning of mental illness experiences, Spirituality, Quality of life, Meaningful life and social roles, Rebuilding life. *Empowerment* • Personal responsibility, Control over life, Focusing upon strengths.

Ways of Understanding Recovery

Since 2009, various perspectives on recovery have been investigated in the literature, including the perspectives of people in different countries, and people with specific experiences. The experience of living with mental health issues varies from person to person and can vary in its nature and severity depending on a range of factors including context, social support networks, other co-existing conditions, physical health, geographical location, and the range of supports that are available. In addition, diverse characteristics such as language, worldview, cultural background, gender, sexual identity and trauma will contribute to the unique nature of recovery for each individual.

Piat et al. (2009) carried out interviews with 54 consumers engaged with Canadian mental health services and identified two different meanings of recovery:

- Recovery attached to illness
    - Recovery means a cure
    - Recovery depends on medication
    - Recovery means returning to my former self

- Recovery as self-determination and taking responsibility
    - Recovery means taking charge in life
    - Recovery is a process
    - Recovery means evolving towards a new self.

The authors suggest that biomedical understandings are still prominent, and that the two conceptualisations will need to be bridged if the consumer voice is to be heard.

Todd et al. (2012) explored in depth accounts of the experience of recovery and self-management by conducting focus groups with people who had been diagnosed with Bipolar Disorder (n=12). Four key themes emerged from participant accounts of recovery, including:

1. Recovery is not about being symptom free
2. Recovery requires taking responsibility for your own wellness
3. Self-management (including building on existing techniques), and
4. Overcoming barriers to recovery (such as negativity, stigma and taboo which can be problematic).

The findings indicated that participants desired recovery-focussed support which assists them to learn to self-manage their experience and overcome barriers to recovery.

Kartalova-O'Doherty et al. (2012) aimed to create a theory of recovery by interviewing consumers in Ireland (n=32). The importance of service providers encouraging participation, promoting hope and belief in recovery was highlighted. The results indicated a main theme of striving to reconnect with life within three life domains or subcategories:

- Reconnecting with self (accepting oneself as worthy and capable of positive change)
- Reconnecting with others (accepting and validating interaction)
- Reconnecting with time, (getting a glimpse of positive future, coming to terms with the past, and actively shaping and executing one's present and future)

The idea of "reconnection" has commonalities with the term "recovery", as recovery is often situated in a community and social context.

Wood et al. (2010) analysed eight consumer narratives about their recovery journey, and identified four overarching themes including:

- Impacts on mental health
- Self-change and adaption
- Social redefinition
- Individualised coping mechanisms[9].

[9] Wood et al. (2010)

In general, these studies have all highlighted the differences between the clinical concept of recovery attached to illness, and personal recovery attached to social and personal change, self-determination, participation and hope. They point to the importance of taking a holistic approach that features the consumer perspective and interpretation of their own experience[10].

These findings about the difference between clinical and personal recovery are also supported by a study investigating whether clinical outcome measures also assess personal recovery[11]. Three recovery measures (Recovery Assessment Scale, Mental Health Recovery Measure, and Self-Identified Stage of Recovery) were compared with four clinical outcome measures (Health of the Nation Outcome Scales, Life Skills Profile-16, Global Assessment of Functioning and Kessler-10). Little relationship was found between them, which provides evidence in support of the concept that clinical measures do not necessarily assess personal recovery, and that there is a qualitative difference between them. Interestingly, while recovery scores improved across the stages of recovery the clinical measures did not, which supports that clinical recovery or symptom reduction is not necessarily a requirement for personal recovery.

Finally, Marshall et al. (2013) in Australia addressed a gap in the literature on carer perspectives of consumer recovery. Carer attitudes (n=82) were compared with mental health workers according to wellbeing, hopefulness and recovery attitudes. The study found that carers were significantly less optimistic about recovery in comparison to workers, and that the type of carer experience (according to severity of symptoms the consumer experiences) predicted hopefulness and wellbeing attitudes.

Stages of Recovery

While there is still no one agreed model of the stages of recovery, a number of efforts have been made since 2009 to further understand what comprises the recovery journey, and consistent agreement continues that recovery is a nonlinear process.

Leamy et al.'s systematic review (2011) has provided a conceptualisation of the stages of recovery using a transtheoretical model of change, including: Pre-contemplation; Contemplation; Preparation; Action; and Maintenance and Growth (Table 2).

[10] Piat et al. (2009); Todd et al. (2012); Wood et al. (2010)

[11] Andresen et al. (2010)

Table 2. Recovery stages mapped onto the Transtheoretical Model of Change[12]

Precontemplation	Contemplation	Preparation	Action	Maintenance
	Novitiate recovery – struggling with disability		Semi-recovery – living with disability	Full recovery – living beyond disability
Stuck	Accepting help	Believing	Learning	Self-reliant
Descent into hell	Lighting a spark of hope	Developing insight/ activating instinct to fight back	Discovering keys to well-being	Maintaining equilibrium between internal and external forces
Demoralisation		Developing and establishing independence		Efforts towards community integration
Occupational dependence		Supported occupational performance	Active engagement in meaningful occupations	Successful occupation performance
Dependent/ unaware	Dependent / aware		Independent / aware	Interdependent / aware
Moratorium	Awareness	Preparation	Rebuilding	Growth
	Glimpses of recovery	Turning points	Road to recovery	
	Reawakening of hope after despair	No longer viewing self as primarily person with psychiatric disorder	Moving from withdrawal to engagement	Active coping rather than passive adjustment
Overwhelmed by the disability		Struggling with the disability	Living with the disability	Living beyond the disability
Initiating recovery			Regaining what was lost/moving forward	Improving quality of life
Crisis (recuperation)		Decision (rebuilding independence)	Awakening (building health interdependence	
	Turning point	Determination		Self esteem

In addition, more recent studies involve in depth investigations into particular stages of recovery and associated components.

Hancock et al. (2011) conducted focus groups with consumers to create a better understanding of what is involved with the later stages of recovery in particular. The findings were used to provide recommendations for the Recovery Assessment Scale (RAS), which has been found to poorly differentiate between consumers who are further along in their recovery journey. The findings suggest that the later stages of recovery involve:

- Accepting your illness, and gaining control over symptoms
- Self-love and optimism
- Doing things for, and experiencing, pleasure
- Contributing through meaningful activity
- Having a diversity of friendships

[12] Leamy et al. (2011)

- Being needed and valued by others, and
- Coming to terms with family relationships.

Clarke et al. (2012) added to the evidence base by assessing the types of goals consumers make (approach versus. avoidant oriented goals) across stages of recovery (moratorium, awareness, preparation, rebuilding, growth) in an Australian sample (n=144). Results found that people in later stages of their recovery journey set more "approach goals', and tended to hold broader life roles than those in earlier stages. This supports the concept that recovery involves movement towards a more meaningful and enhanced self-identity.

Glover (2012) put forward a model including five recovery processes including:

- From passive to active sense of self
- From hopelessness and despair to hope
- From others' control to personal control and responsibility
- From alienation to discovery
- From disconnectedness to connectedness.

Overall, a common continuum between models can be identified from passivity and feeling overwhelmed to a sense of control and action[13].

[13] Hancock et al. (2013)

"When I was first admitted to hospital, I didn't understand the extent of my symptoms. I was experiencing a psychotic episode, and was diagnosed with Schizoaffective Disorder… I had to tackle my mental health issues and found a local activity program. When I started I felt alone, misunderstood and confused. I forced myself to come every day. Soon I realised it was part of my routine and something I look forward to. I now know it has a positive effect. All participants attend the program as part of their recovery journeys. We share our experiences with illness, symptoms and medication and support each other. This reminds me that I am not alone, that others have experienced similar things. I now support others which has increased my self-esteem and confidence. I began to look towards the future and set recovery goals. Seeing my goals and achievements written down gave me confidence and hope. I was very surprised at the number of good things in my life. My self-esteem and confidence has skyrocketed. I'm now living independently, which has been a massive step in my recovery. I've also reconnected with my church and my lacrosse club. This has been so important as I'm once again involved with a sport that I love. I have been accepted by the members of my former club and encouraged to join in with club community events and to take up playing again. I now know it's important to have goals and plans for the future and to work hard to achieve them. I'm very proud of myself and how far I've come in my journey."

– Consumer story on the Mental Health Commission website

What facilitates recovery

A few studies have also explored what contributes to personal recovery. Facilitators identified include the importance of community participation, meaning, hope, relationships supporting recovery, a focus on the individual, social support and the environment[14].

Kaplan et al. (2012) provided evidence on the important role of community participation for recovery. The study explored community participation experiences of "emerging" and "mature" adults with serious mental illnesses, and the relationships between participation, recovery, quality of life and meaning of life (n=233 emerging, n=1,594 mature adults). The areas of participation examined include: parenting, peer support, employment, volunteering, group membership, friendships, intimate relationships, religious/spiritual aspects, college student and civic engagement. The Recovery Assessment Scale (RAS), Quality of Life – QOL interview, and Meaning of Life (MOL) Framework were used to capture data. The findings indicate that those with higher participation activity also had higher recovery, quality of life and meaning of life scores.

[14] Kaplan et al. (2012), Hobbs and Baker (2012), Salzmann-Erikson (2013), Chang et al. (2013)

Chang et al. (2013) investigated the relationship between recovery, the social-environment and individual factors by surveying consumers from a large community mental health organisation (n=124). The Mental Health Recovery Measure (MHRM-R) was used to measure individual recovery, and the Recovery Self Assessment was used to assess the perceived recovery-orientation of the service. A significant positive relationship was found between social support and perceived recovery oriented service quality, and a significant negative relationship was found between psychiatric symptoms and recovery. This clearly demonstrates that social-environmental factors play an important role in recovery, and the possibility of progressing recovery (with social supports) with or without symptoms.

Salzmann-Erikson (2013) conducted an integrative review of what contributes to personal recovery according to consumer perspectives (n=14 articles). Three main themes were identified including:

1. Recovery as an inner process
2. Recovery as a contribution from others, and
3. Recovery as participating in social and meaningful activities.

Again, this study points to the importance of staff adhering to a personal recovery perspective with a focus on consumer need, conveying hope and supporting the person in their recovery process.

However, due to the highly individual nature of recovery, it must be noted that what works for one person may not necessarily work for everyone (Slade 2010).

3.2 Recovery and factors influencing recovery

Summary

While a search was not specifically conducted to investigate the link between recovery and specific populations or factors, a number of studies were found that considered recovery in relation to alcohol and other drugs, cultural diversity, ageing, physical health, forensic populations, homelessness and gender and sexual orientation. This is encouraging given the importance of care coordination and a holistic approach to supporting recovery.

Overall, the studies indicate that there are some differences across particular populations and contexts, and it is clear that a variety of factors must be considered in order to be responsive to each individual and their particular needs.

However despite these differences, many similarities and consistent themes have been identified, for example a focus on being person-centred, strengths based, respectful, inclusive and collaborative. This provides early evidence to support the applicability of recovery to a range of people, situations and environments.

"The diverse concepts behind the term 'recovery' reflect their evolution from different perspectives, historical contexts, and communities of interest; all based on different values, principles and meaning; and therefore, resulting in different goals and practical implications" (Gordon & Ellis 2012, p.1).

Given the increasing emphasis on being holistic and the need for continuity of mental health care, it is clear that recovery oriented systems must involve service coordination across the human services to ensure that an individual's strengths, needs and goals are responded to in an integrated fashion[15].

The importance of service coordination in supporting self-determination and recovery is critical. The evidence clearly shows the benefits of effective service coordination, including fewer hospital admissions, higher levels of functioning, reduced symptoms and improved quality of life, consumer satisfaction and autonomy[16]. Conversely, poor coordination is associated with negative outcomes, including deteriorating health, heightened distress, feelings of hopelessness and helplessness, lower levels of functioning and quality of life, increased hospitalisation, use of crisis services and

[15] SAMHSA (2009)

[16] MHCC (2012)

risk of homelessness[17]. While service systems have traditionally operated in silos, increasing attempts are being made to understand what recovery means in different contexts and across different populations of people, as described in more detail below.

Alcohol and Other Drugs

The notion of recovery can be seen to have roots in the 'addiction movement', alongside the consumer movement, with the creation of Alcoholics Anonymous (AA) signifying the beginning of addiction recovery in 1935[18]**.** However, recovery in the addiction context has traditionally involved a focus on rehabilitation and abstinence, and has been in tension with the mental health understanding of recovery as a personal journey that may or may not involve cure. In response to a lack of agreement on recovery within the addictions field[19], attempts have been made to identify what recovery means to bridge the gap between the two sectors.

Dodge et al. (2010) conducted a literature review and participatory research to create a model of recovery according to the perspective of addiction workers, those recovering from addictions and researchers. The final model includes 7 domains:

1. Physical
2. Bio-marker
3. Chemical dependency
4. Psychological
5. Psychiatric
6. Family/social
7. Spiritual.

O'Connell et al. (2005) conducted a comprehensive review and concluded that a recovery oriented service in both mental health and addiction:

- Encourages individuality
- Promotes accurate and positive portrayals of psychiatric disability while fighting discrimination
- Focuses on strengths
- Uses a language of hope and possibility
- Offers a variety of options for treatment, rehabilitation, and support
- Supports risk-taking, even when failure is a possibility

[17] MHCC (2012)

[18] Sterling et al. (2010)

[19] Dodge et al. (2010)

- Actively involves service users, family members, and other natural supports
- Encourages user participation in advocacy activities
- Helps develop connections with communities
- Helps people develop valued social roles, interests, hobbies, and meaningful activities[20]

Gagne et al. (2007) reported on the common factors between the conceptualisation of recovery and recovery oriented practice across mental health and addiction including:

- Recovery is a personal and individualised process of growth that unfolds along a continuum, and there are multiple pathways to recovery
- People in recovery are active agents of change, and not passive recipients of services
- People in recovery from mental illness and/or addiction disorders often note the important role of family and peer support in making the difference in their recovery
- The values of recovery oriented mental health and addictions systems are based on the recognition that each person is the agent of his or her own recovery and all services can be organised to support recovery.
- Person-centred services offer choice, honour each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction"[21].

In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) outlined 12 guiding principles and 17 elements of a recovery oriented system, which were identified at a National Summit on Recovery (Table 3).

Table 3. SAMHSA Guiding Principles and Elements of Recovery Oriented Systems

12 Guiding Principles	**17 Elements of Recovery Oriented Systems**
• There are many pathways to recovery • Recovery is self-directed and empowering • Recovery involves a personal recognition of the need for change and transformation • Recovery is holistic • Recovery has cultural dimensions • Recovery exists on a continuum of improved health and wellness • Recovery emerges from hope and gratitude	• Person-centered • Inclusive of family and other ally involvement • Individualised and comprehensive services across the lifespan • Systems anchored in the community • Continuity of care • Partnership-consultant relationships • Strength-based • Culturally responsive

[20] O'Connell in SAMHSA (2009)

[21] Gagne et al. in SAMHSA (2009)

• Recovery involves a process of healing and self-redefinition • Recovery involves addressing discrimination and transcending shame and stigma • Recovery is supported by peers and allies • Recovery involves (re)joining and (re)building a life in the community • Recovery is a reality	• Responsiveness to personal belief systems • Commitment to peer recovery support services • Inclusion of the voices and experiences of recovering individuals and their families • Integrated services • System-wide education and training • Ongoing monitoring and outreach; • Outcomes driven • Research based • Adequately and flexibly financed

SAMHSA (2011) released an updated definition of mental health and substance use recovery which captures the key elements of the recovery experience for those with mental disorders and/or substance use disorders: "*It is a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential".* SAMHSA also identified the following four dimensions that support recovery:

- Health: managing one's disease(s), as well as living in a physically and emotionally healthy way
- Home: a stable and safe place to live
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavours, and the independence, income and resources to participate in society, and
- Community: relationships and social networks that provide support friendship, love and hope.

Finally, 10 guiding principles of recovery were identified including:

1. Recovery emerges from hope
2. Recovery is person-driven
3. Recovery occurs via many pathways
4. Recovery is holistic
5. Recovery is supported by peers and allies
6. Recovery is supported through relationship and social networks
7. Recovery is culturally-based and influenced
8. Recovery is supported by addressing trauma
9. Recovery involves individual, family, and community strengths and responsibility
10. Recovery is based on respect.

Ageing Populations

Considering recovery in the context of an ageing population initially caused confusion due to the perception that 'recovery' is not always a feasible option for people as they age, however more recent efforts have begun to establish common themes between the concept of enablement in the Aged Care system and the concept of recovery.

McKay et al. (2012) proposed the integration of a bio-psychosocial model and recovery through a person-centred approach. They investigated the application of person centred and recovery approaches for older consumers in comparison to the bio-psychosocial model. The authors concluded that reform is required to implement recovery and person-centred care into practice to avoid too narrow bio-psychosocial approaches, and to ensure a focus on rights, values and goals to improve outcomes.

Tepper et al. (2013) consulted older adult consumers on their satisfaction of their personal recovery and current mental and physical health. The project tested the hypothesis that older adults are more likely to take their current mental health status into account when predicting their own recovery than younger adults due to their hospitalisation/experiences prior to recovery movement in the 1990s. Indeed, the results reported a correlation between mental health status and recovery ratings for older adults (50+) that were twice as strong than younger adults (<50). This points to the importance of recovery oriented service provision taking into account the personal histories of older individuals, and their tendency to associate improvement with symptom reduction. This may well reflect the views of older generations who were used to the "medical model" of care.

A framework of recovery for working age people was evaluated in the UK to determine whether it has value for older people using mental health services, including those with dementia[22], via interviews with consumers and carers from older persons mental health service (n=38). The authors found that components of mental health recovery are still relevant for older people including: the impact of illness; the significance of personal responsibility; and specific coping strategies. Those aspects no longer relevant include the revision of a sense of identity or seeking peer support. In addition to these, three more areas were identified as distinct to older people:

- The significance of an established and enduring sense of identity
- Coping strategies which provide continuity and reinforce identity
- Associated impact of physical illness.

[22] Daley et al. (2012)

Two more items were also identified specifically for people with dementia, including changing experience over time and support from others. This study provides empirical evidence on how recovery can be applied to older people using mental health services, with a specific need to focus on maintaining identity, empowerment, agency and self-management[23].

Cultural Diversity

"*In recent years, two of the most dynamic areas of inquiry and practice in community mental health have been recovery and cultural diversity. Unfortunately, these two areas have largely evolved in silos, and first generation models of recovery have done little to acknowledge culture"* (Jacobson and Farah, 2012 p. 333).

There have been concerns raised around the applicability of recovery to a culturally diverse context and it is argued that if recovery changes according to context, then research needs to occur in different communities[24]. However, while there is increasing literature on recovery, it is primarily based on majority populations with a gap in the consideration of ethnicity, race and culture[25].

More recent efforts have been made in Australia regarding this issue, for example in 2010, *A Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*, was developed by Mental Health in Multicultural Australia to help public, private and community-managed mental health services evaluate their cultural responsiveness, and enhance delivery of services for and in partnership with Culturally and Linguistically Diverse communities. Key concepts that guide the framework include:

- Cultural responsiveness
- Risk and protective factors
- Culturally inclusive practice
- Consumer and carer participation
- Recovery and cultural diversity.

A number of cross cultural studies regarding recovery have been conducted, for example Fukui et al. (2012) conducted a study investigating the differences in recovery for people with mental illness between the US (n=446) and Japan (n=214) using the Recovery Assessment Scale (RAS). US and Japanese participants responded similarly to RAS components of recovery. However, two domains

[23] Daley et al. (2012)

[24] Slade et al. (2012a)

[25] Slade et al. (2012b)

were systematically different between American and Japanese participants including: Personal confidence and hope, and Reliance on others.

Jacobson and Farah (2012) conducted focus groups with consumers and carers and a community forum in Canada to develop a model of recovery which accounts for culture to assist organisations to provide culturally appropriate recovery oriented services to people with a diversity of backgrounds. The resulting culturally responsive model of recovery highlighted the importance of culture, systems of oppression and privilege, the social determinants of health and history and suggested that "*recovery oriented services need to address families and communities – not just individuals*"[26] (p. 335).

The systematic review and narrative synthesis of personal recovery conducted by Leamy et al. (2011) also explored data on Black and Minority Ethnic (BME) backgrounds and compared the findings with the original conceptual framework, which indicated that there is similarity between the ethnic minority and ethnic majority populations. However BME papers also emphasised the importance of spirituality and stigma in the recovery process, and also culture-specific factors and collectivist notions of recovery as two additional categories.

Slade et al. (2012b) summarised these findings as follows: "*there were 5 main differences in respect of the perspectives on recovery of people from minority communities. These were: an increased emphasis on the role of spirituality and religion; additional stigma and discrimination faced by individuals and their families; culturally specific facilitating factors such as traditional healing practices; individualistic versus collectivist values and the impact that differing values have on the meaning and experience of recovery; and additional barriers at the level of the mental health system, including perceptions of institutional racism. These differences in the perception of recovery need to be taken into account when designing a recovery-orientated service*"[27](p. 100).

Slade et al. (2012) conducted a systematic review on international differences in understanding recovery (n=429 papers) to validate the existing CHIME conceptual framework. The papers originated from 11 countries and largely comprised qualitative research, non-systematic reviews and position papers. The review reported that at the top level of coding (CHIME) there was no real variation between English speaking countries, suggesting that the CHIME dimensions appropriately capture key recovery aspects. However, at the second level of coding there were differences including:

[26] Jacobson and Farah (2012) p. 335

[27] Slade et al. (2012b)

- Connectedness was mostly found in USA and UK (emphasis on community integration and social inclusion)
- Meaning in life was higher in the UK and Canada
- A strengths focus was found in Australia (probably because of the Strengths Based Model and Collaborative Recovery Model).

Aboriginal and Torres Strait Islander People

"There is enormous need to address issues of recovery for Indigenous mental health clients. There is also a need to learn more about the meaning of recovery in the Indigenous context" (Nagel et al. 2012, p. 216)

Aboriginal and Torres Strait Islander people have developed the concept of social and emotional wellbeing which includes the social, emotional, physical and cultural wellbeing of both the individual and the whole community[28]. However, there is not a lot of literature focussing on Aboriginal and Torres Strait Islander social and emotional wellbeing and recovery[29].

Nagal et al. (2012) outlined a number of ways in which concepts of recovery may be different between Indigenous and non-indigenous interpretations, including:

- Context – colonisation, stolen generation and other policies that resulted in oppression as important factors in a recovery narrative
- Social exclusion – the need to overcome stigma and discrimination of mental illness, but also of racism
- Language – including destigmatising and hopeful language, but also plain English and local language
- Worldview – the way in which mental illness and treatment are understood
- Holistic planning – ensuring that all aspects of life are addressed with additional focus on culture, cultural identity, family and kinship and language and country.

However, many similarities were also identified including:

- The centrality of people's stories
- Developing a shared understanding
- Utilising tools to support goal setting and collaborative care planning
- A focus on relationships, and

[28] Victorian Department of Health (2011)

[29] Victorian Department of Health (2011)

- The importance of social inclusion and meaningful roles.

It is proposed that recovery oriented practice would ensure that a worker is in fact listening and responding to the individual and community needs as identified by Aboriginal and Torres Strait Islander people, through being holistic, culturally responsive and person-centred[30]. *"Culturally adapted recovery approaches to Indigenous mental illness are thus an important component of closing the gap in Indigenous health"* (Nagel et al. 2012, p. 216).

Physical Health

There is increasing recognition of the highly interlinked nature of mental and physical health. People with more severe mental illness on average die 25 years sooner, and from major chronic health conditions two or three times more than the general population including heart disease, diabetes, metabolic syndrome and respiratory disease (with smoking as the leading cause)[31]. Further, many people will live with more than one of these health issues or with other significant physical conditions, which can lead to a significantly increased risk of depression and anxiety. As such, these complex relationships impact directly on the recovery process.

Physical health has been identified as a clear priority for consumers, for example in a study looking at consumer goals according to stage of recovery in Australian mental health services, nearly a quarter of participants rated physical health as the most important goal and it was recorded significantly more frequently than other goals[32].

While nothing emerged in the literature search regarding physical health and recovery specifically, the work of Lawn around self-management of chronic illness by people with mental illness was identified. Lawn et al. (2012) outlined a self-care, self-management and self-management support approach. While the emphasis is a little different to a recovery approach, there are many features in common, for example:

- An accepting empowering environment where the person feels safe
- Non judgemental assistance
- The client is respected and listened to
- Culture is respected
- A collaborative, curious approach

[30] Victorian Department of Health (2011)

[31] Lawn (2012)

[32] Clarke et al. (2012)

- The change is intrinsic (of fundamental value to the person).

Lawn et al. (2012) evaluated a model of chronic condition self-management support with people with a mental illness and found that:

- Peers working alongside people can make all the difference
- People were motivated to look after their physical health, they just needed relevant support to do so
- Following support, there was a reduction in problems identified and hospital admissions and an improvement in quality of life
- By workers simply asking people about what they already knew of their physical health conditions, what works, what was challenging and what "the problem" was they gained a greater understanding of the person and their situation.

Lawn et al. (2012) concluded that *"how we take the steps with people is the most important thing. There are important system improvements that we can make to create a real difference"* (Lawn 2012, p. 16)

Trauma

> *It wasn't until I finally entered a recovery oriented, trauma-informed treatment program a little more than four years ago, where I felt safe and respected, that I could begin to heal...Someone finally asked me 'What happened to you?' instead of 'What's wrong with you?'*
>
> - Tonier Cain, survivor (MHCC 2012)

"Trauma-informed approaches like recovery orientation are person centred and involve sensitivity to individuals' particular needs, preferences, safety, vulnerabilities and wellbeing, recognise lived experience and empower consumers to participate in decision making" (Victorian Department of Health, 2011 p. 12).

Recovery oriented services must be trauma informed, and workers must employ trauma informed care and practice to support people on their recovery journeys. This is important due to the high prevalence of trauma experienced by people with mental illness[33] and is compatible with a person-centred recovery oriented approach which focuses on individual experience, needs, preferences and wellbeing[34]**.** Becoming trauma informed requires a re-conceptualisation of mental health service

[33] Kezelman and Stevropoulos (2012)

[34] Victorian Department of Health (2011)

delivery to incorporate greater awareness of and sensitivity to the possibility of existing trauma in the lives of people with mental illness, and the possibility of traumatisation or re-traumatisation.

In providing mental health services, trauma informed care is an integral part of recovery oriented practice which clearly acknowledges and articulates "*that no one understands the challenges of the recovery journey from trauma better than the person living it*" [35]. Survivors of violence and trauma know their history, struggles, means of survival and coping, and what promotes healing, better than anyone else. Survivors frequently encounter services that mirror the power and control experienced in abusive relationships that caused past trauma. In the traditional program of services, healing and recovery is difficult and the risk of re-traumatisation is real. Trauma-informed organisational cultures offer the possibility of enhanced collaboration for all participants in the human service system and:

- Incorporate knowledge about trauma in all aspects of service delivery and practice;
- Are hospitable and engaging for survivors—and for all
- Minimise re-victimisation–"do no harm;"
- Facilitate healing, recovery, empowerment.

Specifically, a trauma-informed approach, similar to recovery oriented practice, also involves fundamental shifts in thinking and practice at all program levels. The core values of Trauma Informed Care are:

- Safety: Ensuring physical and emotional safety
- Trustworthiness: Maximising it, making tasks clear, and maintaining appropriate boundaries
- Choice: Prioritising consumer choice and control
- Collaboration: Maximising collaboration and sharing of power with consumers
- Empowerment: Prioritising consumer empowerment and skill building.[36]

The eight foundational principles that represent the core values of trauma-informed care and practice are:

1. Understanding trauma and its impact
2. Promoting safety
3. Ensuring cultural competence
4. Supporting consumer control, choice and autonomy
5. Sharing power and governance
6. Integrating care

[35] MHCC (2011)

[36] MHCC (2011)

7. Healing happens in relationships
8. Recovery is possible.[37]

Forensic Populations

It has been recognised that while the recovery approach has great potential value for forensic service users, there can also be unique difficulties that must be considered and some commentators have questioned whether 'recovery' can be applicable to forensic contexts at all[38].

Dorkins and Adshead (2011) highlighted that the experience of social exclusion for forensic populations is likely mandated by a risk-averse society, and noted a contradiction between advocating for personal choice while detaining people involuntarily. Specifically, they identified four area of recovery that are challenged by this population including:

- The values and identity of forensic service users
- Social exclusion as a community response to trauma and violence
- Empowerment for those who misuse power and do not respect the choices of others
- Hopelessness and the offender identity.

Dorkins and Adshead (2011) outline a number of examples that illustrate these tensions, for example:

- The recovery approach argues for the values of the person to be respected and upheld, however there is no clarity around how to manage this when a person holds anti-social values that impact negatively upon other people
- The recovery approach assumes that people want to be citizens, however the forensic population have anti-social values which undermine the social value system in their communities
- There is an unclear distinction between 'mad' and 'bad', and where therapy is provided it is not usually to uphold a person's values but to change them
- Finally, regarding autonomy, forensic populations are not able to define and act on their own risk[39].

However, in contrast, Roberts (2012) responded by reframing these tensions, for example:

- Considering social inclusion in a context where society has deliberately rejected forensic populations can include seeing the forensic campus as a community within which to

[37] MHCC (2011)

[38] Dorkins and Adshead (2011)

[39] Dorkins and Adshead (2011)

facilitate opportunities for meaning, reciprocal relationships, development of self-esteem, responsibility and agency

- Re-framing the discomfort with the person 'as expert' with values to uphold to an acknowledgement of the person's expertise in *their own experience*. This perspective can be valued alongside experts by training and research and how these perspectives rank will ultimately depend on the context (e.g. legal, capacity, choice)
- The discrepancy of viewpoints between the person and staff may be consistent however the issue is not about accepting that the person is always right but to see the person not just as the problem but as a part of the solution, etc.

Roberts (2012) points to the importance of maintaining a focus on supporting self-management and facilitating realistic hopefulness – *"people who become 'forensic services users' have not always been and (most) will not always be such. The wider concern to combat stigma seeks to avoid conflating personal identity with service utilisation or diagnosis and emphasises that people who use services are, firstly and primarily, people"* (Roberts 2012, p. 190)

Gender and Sexuality

Gender and sexuality must be taken into account when delivering recovery oriented services, as the experience of mental illness and psychosocial disability is different for women and men[40] and for people with diverse sexuality and sexual preferences. Unfortunately, there appears to be a lack of studies supporting a greater understanding of the different experiences of distress and service interaction due to 'heterosexism' and LGBTI preferences in relation to the recovery journey[41].

A study in Canada explored the perspectives of LGBTI women on mental health recovery (n=13). Of these women, four did not know what personal recovery is, and six did not know about the notion of services embedding a recovery approach. Only three women in the study actually knew what was meant by the term recovery. As such, some women reported being uncomfortable with the language of recovery due to medical model interpretations of this term, indicating a lack of exposure to conversations regarding personal recovery. The results also indicated that half of the women questioned whether recovery is possible, and critiqued the notion of recovery due to:

- Participants identifying as 'mad' and being OK with this
- Participants who are sexual assault survivors, who report they will never 'recover' from this

[40] Victorian Department of Health (2011)

[41] Daley in Das (2012)

- Participants querying 'what am I meant to be recovering from?' and with a perception that recovery is a form of heteronormativity, including a pathologisation of LGBTI as equivalent to 'mental illness'.

While this study was intended to be about exploring views of personal recovery, it instead emphasised how medical model recovery and in particular the view of recovery as 'cure' or 'return to before' is not an appropriate paradigm for some LGBTI people[42].

The National LGBTI Health Alliance (2012) has in fact advocated for recovery oriented mental health services. They consider the approach of recovery to be inclusive of people who often experience marginalisation. Further, *"the recovery model concepts of self- determination, self-management, personal growth, empowerment, choice and meaningful social engagement are congruent with LGBTI-affirmative practice and with the processes of "coming out"* (LGBTI Health Alliance 2012).

Homelessness

Finally, research demonstrates the highly interlinked nature of mental illness and homelessness[43].

Anglicare (2011) undertook a study investigating this relationship in Tasmania including interviews with people with lived experience of mental ill health and homelessness. The results of this study highlight the importance of recovery oriented service delivery to people who are homeless and have a mental illness, with interviewees stating that "*the establishment of trusting relationships, combined with a recovery approach to service development and delivery assists personal healing*" (p. 77). This study also provided a list of potential recovery principles for both mental health and homelessness services as shown in Table 4.

Table 4. 'Recovery' in mental health and homelessness

Recovery principle	What can recovery mean in mental health practice?	What can recovery mean in housing practice?
Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms and problems.	A move away from a focus on the removal of symptoms as the prime purpose of mental health services. (E.g. Learning to live with voices may be the focus rather than eradication). A focus on the positive aspects of each person's life. The role of mental health workers becomes 'recovery guide' to help the individual reach their goals in a way of their choosing.	A move away from a focus on homelessness, towards offering stable supported long- term housing as the prime purpose of homelessness services. A focus on the positive aspects of each person's life. The role of housing workers becomes 'recovery guide' to help the individual reach their goals in a way of their choosing. Social

[42] Daley in Das (2012)

[43] Anglicare (2011)

	Social inclusion becomes increasingly important.	inclusion becomes increasingly important.
Recovery represents a movement away from pathology, illness and symptoms to health strengths and wellness.	The past emphasis on illness has led to a neglect of what it is that keeps people well and gives their life value and meaning. Staying well and building support structures become important. Contingency plans, joint crisis plans, negotiated safety plan and advanced directives which honour people's preferences become increasingly important.	The past emphasis on homelessness has led to a neglect of 'homefulness', including long-term aims of social inclusion and meaning. Staying housed and building support structures become important. Financial/ budget plans, joint crisis plans, negotiated maintenance plans, and advanced directives which honour people's preferences become increasingly important.
Hope is central to recovery and can be enhanced by seeing how we can have more active control over our lives and by seeing how others have found a way through.	Having people with lived experience of mental health problems as workers and trainers makes training more real and can lead to culture change. Some stories are heroic examples of people who have refused to accept dire predictions of outcome. Training service users in self management and setting their own agendas when working with professionals becomes important in achieving a partnership way of working.	Having people with lived experience of housing instability and homelessness as workers and trainers makes training more real and can lead to culture change. Training service users in self management and setting their own agendas when working with housing workers becomes important in achieving a partnership way of working.
Self management is encouraged and facilitated. The processes of self management are very similar though what works may be very different for all of us. There is no 'one size fits all'.	Individuals define their own goals and agenda. The role of workers is to help them achieve it in ways and settings which are meaningful and acceptable. A move away from providing 'group solutions' which are defined by professionals without reference to actual service user need. Empowering approaches such as the Wellness Recovery Action Plan (WRAP) are offered in conjunction with housing workers.	Individuals define their own goals and agenda. The role of workers is to help them achieve it in ways and settings which are meaningful and acceptable. A move away from providing transitional solutions which are defined by existing housing stock and homelessness services, without reference to actual service user need.
The helping relationship between clinicians and patients moves away from being expert - patient to being closer to peer support; as coaches or partners on a journey of discovery. Clinicians are 'on tap, not on top'.	Therapies and treatments are evaluated via the recovery framework according to whether they give or take away power from people. Working in partnership as equals replaces 'service user involvement' as an ideal. The qualities and attitudes of staff become at least, if not more, important than skills and knowledge.	Housing and supports are evaluated via the recovery framework according to whether they give or take away power from people. Working in partnership as equals places 'service user involvement' as an ideal. The qualities and attitudes of staff become at least, if not more, important than skills and knowledge.

3.3 Recovery oriented practice

"*The recovery orientation of services refers to the extent to which mental health staff and services attempt to facilitate or promote personal recovery, and encompasses different aspects of service delivery and practices that are believed to do this"* (Williams et al. 2012, p. 1828).

"*In summary, then, recovery oriented practices identify and incorporate a person's own goals, interests and strengths in the effort to support the person's own efforts to manage his or her condition while pursuing a meaningful life in the community"* (Davidson et al. 2009, p. 326).

An ongoing challenge involves uncertainty around how to translate recovery principles into clear practice approaches[44], and it has been argued that there has still been little progress at the practice level to embed a recovery orientation into service provision[45]. As a relatively new approach to practice, it is proposed that there is not yet enough information to identify what comprises genuine recovery oriented practice, nor how recovery values can or should be delivered in practice[46]. Thus, there is no one comprehensive approach or plan to embed recovery into practice, and it remains a significant challenge[47]**.**

> "*The policy imperative to support personal recovery has developed ahead of a clear evidence base of what makes a service recovery oriented. This lack of evidence stems partly from the lack of clarity regarding the definition of recovery and how it is conceptualised"* (Williams et al. 2012, p.1828).

While efforts have been made to embed a recovery orientation in organisations, consumers still report that this is largely only rhetoric, without appropriate structural and transformational change[48]**.** A number of reasons for this have been identified including an environment that emphasises risk management, the significant variation within and between individuals which prevents the possibility for developing *one* recovery model, a paradigm shift from traditional approaches including changes in power differentials, structural barriers and systemic stigma[49].

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[44] Kidd et al. (2010)

[45] Slade (2010); Smith-Merry et al. (2011)

[46] Davidson et al. (2009); Smith-Merry et al. (2011)

[47] Ramon (2011); Boardman & Shepherd (2011)

[48] Slade (2009b)

[49] Slade (2010), Gilburt et al. (2013)

Genuine efforts to guide the implementation of recovery oriented practice are occurring, however it is also noted that this mostly involves systemic structural change with a focus at the organisational or management level as opposed to the frontline worker level, and often little explanation is provided as to the process required to deliver the change at the coalface[50]**.** It is also apparent that less has been done to transform service provision in hospital settings in comparison to community mental health settings, despite being a considerable component of "the continuum of care"[51].

> "*Establishing recovery oriented regimes in acute admission wards is a bold way in which to implement recovery practice, given that they are the symbolic site of a mental health crisis at its height, where a high level of control is exercised, risk avoidance is focused upon, and issues of care and control may conflict. Yet it is also the site where the service user and their carers are grateful for positive interest and attention and more ready for change"* (Ramon 2011, p. 42).

Advances in the development of an evidence base are occurring[52] and it is argued that, "*the heart and soul of the recovery movement – consumer-helper collaboration, hopefulness, self-determination, and competency – have received robust empirical support"*[53]*.* Further, guidelines for developing recovery oriented services are emerging[54] and evidence clearly suggests that recovery oriented service delivery improves consumer outcomes[55]**.**

Implementation and Evaluation

SUMMARY

Despite progress in awareness and uptake of a recovery approach and an increase in guidelines and frameworks to guide implementation, recovery oriented service delivery is still not a part of every day practice and there is still a long way to go.

The studies found in relation to recovery oriented practice highlighted the importance of change occurring at every level of an organisation, including policies and procedures, through to management structures, through to front line staff and practice. Studies also emphasised the importance of consumer participation in the design, delivery and evaluation of services.

[50] Ramon (2011)

[51] Tsai et al. (2010)

[52] Slade et al. (2012a)

[53] Tilsen and Nilund (2010)

[54] Leamy et al. (2011)

[55] Kidd et al. (2011); Feeney et al. (2013)

Some ways to support recovery in practice included through relationships, values and culture, leadership support, strengths based assessment, action planning, supporting self-directed care and increasing person centred care, planning for crisis together, changing the way 'risk' is understood, education and training and quality improvement processes. The importance of sharing information was also highlighted.

The new *National Recovery Oriented Mental Health Practice Framework* (2013) in Australia includes the following key domains: Person 1st and holistic; Enabling and supporting recovery; organisational commitment and workforce development; and action on social inclusion and social determinants of health, mental health and wellbeing.

An increasing number of guidelines and frameworks have been developed since 2009, which provide comprehensive information on the implementation of recovery oriented practice.

In 2009, Slade produced a document for Rethink in the UK outlining 100 ways to support recovery. An article was also published on the contribution of mental health services to recovery based on the Personal Recovery Framework.[56] A number of ways a worker can support an individual in their recovery journey were identified including fostering relationships, promoting well being, offering treatments and improving social inclusion. One hundred ways in which workers can provide recovery oriented services were documented in detail as follows:

- Relationships
    - Supporting peer relationships, professionals, other
- The foundations of a recovery mental health service
    - Make values explicit, embed values into working practices of the mental health system, refine practices through performance feedback
- Assessment
    - Using assessment to develop and validate personal meaning, amplify strengths, foster personal responsibility, support positive identity, using assessment to develop hope,
- Action planning
    - Recovery and treatment goals
- Supporting the development of self-management skills

[56] Slade (2009), Slade (2009b)

    - Supporting development of agency, empowerment, motivation, contribution of medication, risk taking
- Recovery through crisis
    - Preventing unnecessary crises, minimising loss of personal responsibility during crisis, supporting identity in and through crisis
- Recognising a recovery focus in mental health services
- Transformation of the mental health system
- Electronic resources to support recovery.

The Sainsbury Centre for Mental Health in London has released two reports by Boardman and Shepherd (2009 & 2011) including a framework for organisational change and a guide for putting recovery into practice. The framework includes a 10 point plan for implementing a recovery orientation including:

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user- led education and training programs
3. Establishing a 'Recovery Education Unit' to drive the programs forward
4. Ensuring organisational commitment, creating the 'culture'
5. The importance of leadership
6. Increasing 'personalisation' and choice
7. Changing the way we approach risk assessment and management
8. Redefining user involvement
9. Transforming the workforce
10. Supporting staff in their recovery journey
11. Increasing opportunities for building a life beyond illness.[57]

The papers also outline a methodological approach for addressing these challenges and successfully implementing recovery oriented practice, including:

1. Stage 1 Engagement;
2. Stage 2 Development; and
3. Stage 3 Transformation.

Both of these documents highlight the importance of commitment and transformation at every level of an organisation including: organisational principles; policies; recruitment and supervision processes; quality and performance management processes and a consistent reflection of recovery-orientation in the language used and values espoused and acted upon by the organisation. They

[57] Sainsbury Centre for Mental Health (2009)

also emphasise the importance of consumer participation and satisfaction and training and education for staff to ensure that the following are embedded in regular practice:

- Provision of information and options to consumers;
- Encouragement of self-management;
- Joint planning for crisis management;
- Shared decision making regarding medication and the provision of choice over treatments;
- Preferences for clinicians[58].

In Australia, two frameworks have been developed including the Victorian Department of Health Framework for recovery oriented practice, and the *National Mental Health Recovery Framework*. Both take a similar approach by outlining key domains and key areas within each section (Table 5).

Table 5. Frameworks for recovery oriented practice developed in Australia

Craze (2013) National Recovery Oriented Mental Health Practice Framework Project	**Victorian Department of Health (2011) Framework Recovery Oriented Practice**
Domains • Person 1st and holistic • Enabling and supporting recovery • Organisational commitment and workforce development • Action on social inclusion and social determinants of health, mental health and wellbeing Key capabilities: • Core principles • Behaviours attitudes skills and knowledge • Good practice examples • Good leadership examples • Opportunities • Resources	Domains: • Promoting a culture of hope • Promoting autonomy and self-determination • Collaborative partnerships and meaningful engagement • Focus on strengths • Holistic and personalised care • Family, carers, support people and significant others • Community participation and citizenship • Responsiveness to diversity • Reflection and learning Areas: • Core principles • Key capabilities • Good practice examples • Good leadership examples

Finally, a qualitative analysis of international recovery oriented practice guidance (n=30) was conducted by Boutillier et al. in 2011 to identify key characteristics of recovery oriented practice across a diversity of differing sources, and develop a conceptual framework to assist with the implementation of recovery orientation into practice.

The conceptual framework comprises 16 themes separated into 4 practice domains:

[58] Sainsbury Centre for Mental Health (2009)

1. Promoting citizenship
    a. Seeing beyond ‘service user’
    b. Service user rights
    c. Social inclusion
    d. Meaningful occupation
2. Organisational commitment
    a. Recovery vision
    b. Workplace support structures
    c. Quality improvement
    d. Care pathway
    e. Workforce planning
3. Supporting personally defined recovery
    a. Individuality
    b. Informed choice
    c. Peer support
    d. Strengths focus
    e. Holistic approach
4. Working relationship
    a. Partnerships
    b. Inspiring hope.

An increasing number of studies have also been published since 2009 on the implementation and evaluation of recovery oriented practice. This includes a focus on implementation process, facilitative factors and outcomes.

A study on service provider experiences and perspectives on recovery oriented reform in Canada identified three themes emerging from nine focus groups (n=68) including:

1. Positive attitudes towards recovery oriented reform
2. Scepticism towards recovery oriented reform
3. Challenges associated with implementing recovery oriented practice, specifically:
    - Conceptual uncertainty and inconsistent recovery meanings
    - Applying recovery oriented practice with some populations in some contexts
    - Bureaucratisation of tools measuring recovery orientation
    - Low leadership support

- Social stigma and social exclusion[59].

Piat and Lal (2012) outlined seven key strategies that were implemented by the Mental Health Centre in Denver (US) and in unison created recovery oriented organisational change, as follows:

1. Vision and persistent leadership
2. Consumer inclusion and involvement
3. Seize opportunities to add recovery oriented ideas into clinical practice
4. Providing the right level of service at the right time
5. On site staff recovery training
6. Hiring the right people
7. Outcome driven learning and quality improvement.[60]

This paper demonstrates that an organisation can become recovery oriented to make work more meaningful however it requires commitment, a vision, an ability to recognise and use every opportunity for change and importantly, of patience.

Clossey et al. (2011) demonstrated how an Appreciative Inquiry (AI) approach can be effective for implementing a recovery orientation by facilitating organisational change and transformation. It is noted that appreciative inquiry and recovery share common values such as empowerment, community, positive emphasis, healing and hope. The paper reviews literature and concludes with the importance of organisational culture when implementing new service approaches.

Ramon (2011) also explored organisational change in the context of recovery oriented services in the NHS in the UK. This review of approaches highlights the importance of a participatory process, with consumers and 'grass roots' workers owning innovative change instead of management to ensure genuine organisational transformation. It was concluded that the organisational change process needs to be viewed positively by all those involved, particularly by organisation leaders.

Smith-Merry et al. (2011) conducted an analysis of how four technologies, including recovery interviews, the Scottish Recovery Indicator, Wellness Recovery Action Planning (WRAP) and peer support have progressed the implementation of a recovery orientation in Scotland using documentary analysis and interviews. The different strategies were discussed in terms of their different contributions, concluding with the recommendation that a multi-pronged approach be taken to embedding recovery oriented practice in mental health systems.

[59] Piat and Lal (2012)

[60] Olmos-Gallo et al. (2012)

In addition, Bradstreet (2012) outlines the development of recovery in Scotland including new learning, workforce competencies and training and national initiatives. Bradstreet specifically focussed on the potential to build on this progress to better support personal recovery beyond statutory services, and highlighted the importance of public attitudes and community based learning approaches.

Brown et al. (2010) investigated factors that predict a recovery orientation in county departments (n=12) of mental health in California at the individual staff level and county department level, considering individual characteristics (demographics, education and experience) and organisational culture ('adhocracy', 'clanish', 'hierarchical' and 'market oriented' and leadership and economic resources). Results show that staff being highly educated (graduate level) results in a higher recovery orientation, and that staff age has an inverse relationship with recovery orientation. Organisational culture was also found to be critical in fostering a recovery orientation, where more flexible and innovative organisations ("adhocratic" culture) corresponded with a higher reported recovery orientation. Finally, it was also demonstrated that more resources corresponded with a higher reported recovery orientation (perhaps because it costs to undergo transformation). Overall, findings suggest that education, organisational culture, leadership and economic resources are critical to embedding a recovery orientation.

Another study exploring consumer views (n=40) on the priorities for supporting recovery was conducted in South Africa specifically considering the policy and service developments that are required[61]. Priorities identified include addressing stigma, discrimination and disempowerment, and the links between poverty and mental health. Strategies identified for overcoming these barriers include campaigns to raise awareness, rights protection through policy and legislative reform, establishment of a national lobby advocating for change, and user empowerment. Overall, the research suggests the importance of:

- Giving priority to service user involvement in policy and service reform;
- Creating empathic alliances to promote user priorities;
- Building enabling partnerships to affect these priorities[62].

LaBoube et al. (2013) addressed the importance of including people in all aspects of the change process i.e. planning, development and delivery of services and research and in particular program evaluation, and demonstrated that this process in itself will support recovery. An evaluation of

[61] Kleintjes et al. (2012)

[62] Kleintjes et al. (2012)

Texan services for veterans included focus groups with consumers, meetings with staff and surveys with collaborators. The findings indicated the benefits of including consumers in recovery program evaluation in relation to SAMHSA's Fundamental Components of Recovery (2006) – empowerment, responsibility, hope, peer support, a holistic approach, individualised and person centred care, respect, non-linear change, promotion of strengths and self-direction. Challenges were also identified including power differentials, aspects of leadership, burnout, or insufficient knowledge, attitudes or skills. Finally, the importance of flexibility, support, consistency, visibility, and buy-in were identified.

Other studies have looked at particular elements of implementation and practice. For example, Matthias et al. (2012) investigated the actuality of supported decision making as an important component of recovery oriented service delivery. Direct observation was undertaken of 40 appointments at a recovery oriented community mental health centre (4 providers, 40 consumers with serious mental illness) to understand how consumers and providers make decisions in consultations on medication management. Thematic analysis of the data illustrated that while providers often invited consumers to participate, and consumer driven decisions created more discussion and disagreement with consumer opinion often prevailing, overall providers were found to initiate most decisions. This suggests a high level of person centred service provision, but not supported decision making.

Three studies in Canada and the US have investigated the relationship between recovery and Assertive Community Treatment (ACT). One study measured the recovery orientation and ACT fidelity by consulting with ACT teams (n=67), staff (n=518), team coordinators (n=67), clients (n=1400) and reported a moderate to high level of recovery orientation in ACT teams, and more specifically low coercive practice activity.[63] The other study employed a mixed methods approach with two ACT teams, with 9 staff and 43 consumers on one team and 12 staff and 74 consumers on another to compare a recovery oriented team with low recovery orientation. The results showed that the recovery oriented team had higher expectations for consumer recovery, involved consumers in planning and had higher goal-direction and had a lower use of 'control mechanisms' e.g. daily medication delivery[64]. Finally, a third study provided early support for the positive impact of recovery orientation on consumer outcomes for people with SMI, including better outcomes in legal involvement, hospital days, education involvement and education domains[65].

[63] Kidd et al. (2010)

[64] Salyers et al. (2012)

[65] Kidd et al. (2011)

Slade (2010) discussed measuring and evaluating recovery in mental health services in the absence of universal quality standards for recovery oriented practice. Slade discussed the possibility of focusing on what is occurring in the worker-client relationship as an indicator for recovery oriented service delivery, given the importance of relationships to supporting recovery. In addition, Slade identified two possible domains by which to measure a recovery orientation including belief markers and discourse markers (Table 6). Finally, Slade proposed an approach of measuring 1) quality of life and 2) progress towards personal goals to evaluate service success in achieving recovery outcomes.

Table 6. Belief Markers outlined by Slade (2010)

Belief Markers	
Beliefs in traditional mental health services	**Beliefs in recovery-focussed mental health services**
We already "do" recovery	Recovery is a journey not a destination, and we are on the way, but have a long way to go
Recovery begins with recognising you have a mental illness	Recovery begins by reclaiming a sense of who you are
My job is to diagnose or formulate, then provide treatments or interventions for mental illness	My job is to support the person in their journey towards a more meaningful and enjoyable life
My primary approach to relating to consumers is as an expert	My primary approach to relating to consumers is as a coach or a mentor
I have a duty to intervene	I have some must-dos, but I employ several approaches to avoid my agendas dominating our work together
I decide when compulsory treatment is necessary	Approaches such as 'Advance Directives' minimise the extent to which I decide when compulsion is necessary
Staff and consumers are fundamentally different – 'they' have a mental illness, 'we' do not	Staff and consumers are fundamentally similar – we are all trying to live a meaningful and enjoyable life
It is better not to be open if I have my own experience of mental health problems	Being open with other staff and clients about my own strengths and vulnerabilities is a positive asset
Discourse markers	
Clinical team	**Potential alternative**
Case management	Recovery support
Case presentation	Recovery presentation
Has a diagnosis of…..	Meets criteria for a diagnosis of..
Patient/consumer/peer etc.	Ask the person how they want to be referred to
Treatment-resistant	Not benefitting from our work with him/her
The treatment aims are…	The recovery processes are…
Maintaining boundaries	Creating sustainable relationships
Introducing as "I am Dr. Smith"	"Please call me Sam, or Dr Smith, as you prefer"
Maintenance, stabilisation	Consolidating gains
Risk management	Harmful risk and positive-risk taking

Workers, training and competencies

SUMMARY

Since 2009, many studies have supported the importance and effectiveness of training to improve staff knowledge, attitudes and skill around recovery oriented practice. Many studies also emphasised the importance of consumer involvement in training to make sure that learning is grounded in lived experience. In addition, it was found that training was more effective if it focussed on skill development as opposed to theory.

Providing recovery oriented services means that workers have to become coaches, mentors, and partners rather than 'experts'. A number of efforts have been made to change education curricula and identify key skills required to implement recovery oriented practice. Some key competencies identified included: facilitating participation, providing choice, belief in and hope for consumer recovery, supporting self-management and self-directed care, being holistic and strengths based, building relationships and using positive language.

It is increasingly apparent that training is critical to the rollout of recovery oriented service delivery and to enable them to support the empowerment of consumers[66].

There is growing support for the incorporation of recovery concepts in training, and increasing efforts to identify recovery oriented practice competencies empirically for a diversity of practice settings[67]. A number of key factors for recovery oriented service delivery also arise including an emphasis on power differentials and ensuring partnership, participation and choice[68] and a shift for workers to becoming a coach, mentor, facilitator and partner[69].

Since 2009, an increase in studies investigating the effectiveness of recovery training for staff have been conducted, each confirming the importance of recovery training and the difference it makes to staff knowledge, attitudes and practice approaches, including higher optimism for consumer recovery and more holistic approaches[70].

[66] Boardman and Shepherd (2011)

[67] Chen et al. (2013); Razzano et al. (2010)

[68] Roberts et al. (2013)

[69] Boardman in Feeney et al. (2013)

[70] Tsai et al. (2011), Salkeld et al. (2013); Feeney et al. (2013); Wilrycx et al. (2012)

Two studies have investigated the integration of recovery oriented education into professional education curricula. Razzano et al. (2010) involved a curricular transformation initiative in response to the call for pre-service training to incorporate recovery strategies within an evidence based practice context. The Recovery Education in the Academy Program (REAP) is designed to integrate recovery principles and self-determination and other evidence-based practices into medical, social and behavioural sciences curricula (medical students, psychiatry residents, psychologists, social workers) and be used as a replicable framework for embedding recovery training across different disciplines.

One study demonstrated that specific and practical training, for example learning skills, is more effective than general and inspirational training, for example learning attitudes[71]. Another study conducted a review and workshop of implementing recovery and organisational change, with a focus on the possible contributions of people with lived experience of mental illness to training and workforce development. Findings suggest the value of collaborative co-working and lived experience, training, research and evaluation[72].

Stratford, Brophy and Castle (2012) aimed to create training in recovery for psychiatric registrar trainees in Australia, focusing on: hope, holding the hope, the relationship, person-centred practice, understanding and valuing difference, the use of positive language and wellbeing. The study emphasised the importance of training being delivered by person with lived experience and supporting hope, power differentials and a collaborative approach which demands new skills, values and knowledge. Salkeld, Wagstaff and Tew (2013) evaluated a recovery oriented training program that was delivered jointly to service users and staff. It was found that the medium and content of the training program challenged the construction professional relationships and that staff (n=4), interviewed six months later, thought the shared training was a powerful experience that has created ongoing change in relationships and professional identities. The four themes were:

- Power relationships
- Barriers and resistance
- Feeling safe/opening up as a person
- Inspiration/transformational learning.

Finally, a study evaluating the implementation of recovery oriented practice through mental health system wide training was conducted by Gilburt et al. (2013) using a quasi-experimental mixed methods design, including four workshops and an in-team half day session (n=342), auditing care

[71] Tsai et al. (2010)

[72] Roberts et al. (2013)

plans (baseline and following, n=673) and interviews 3 months following training. Significant changes in recovery orientation were found following the training (i.e. 46 changes to care plans were made in the control group in comparison to 573 changes made in training group), and nine key themes arose from the qualitative analysis in two areas:

1. 'Recovery, individual and practice'
    a. Care provision
    b. Hope
    c. Language
    d. Ownership
    e. Multi-disciplinarity.
2. 'Systemic implementation'
    a. Hierarchy and role definition
    b. Training approaches
    c. Measures of recovery
    d. Resources.

These findings highlight the importance of training to the facilitation of change and to embedding a recovery orientation into practice. They clearly indicate the importance of consumer involvement in training so it is grounded in lived experience. However, it also points to the challenges that continue to exist at the systemic level, including the conceptualisation and measurement of recovery and organisational commitment[73].

In terms of competencies, it is argued that while mental health providers are trained to have respect for consumers, be available and listen (although perhaps to different degrees), major gaps involve supporting consumers to take control, believe in their strengths and broaden their approach away from deficit models of practice[74]**.** The skills, knowledge and attitudes required to be recovery oriented, holistic, strengths based and empowering are particularly challenging for workers who have undergone 'clinical training' with a focus on deficit, diagnosis, treatment and risk[75]. A range of authors have specifically identified competencies central to recovery oriented service provision. Competencies for acute mental health care workers have been identified by two studies. NHS Education for Scotland (2010) outlined the values, skills and knowledge required by nurses within hospital and community settings in four areas:

- Rights, values and recovery focused practice

[73] Gilburt et al. (2013)

[74] Ramon (2011)

[75] Slade (2009b).

- Supporting recovery from acute crisis
- Making a difference in acute care
- Sharing positive risk taking[76].

Chen et al. (2013) identified salient recovery competencies that hospital providers require including attitudes, knowledge, skills and behaviours through interviews and a literature review. Eight core competencies and 4-10 sub-competencies provide the basis for a framework to guide workforce education. Three points of tension were highlighted including:

- Environmental level tensions: poor physical environment, inflexible routines, unsafe atmosphere, limited resources and support, hierarchical power structure, institutionalisation
- Personal level tensions: psychotic symptoms, behavioural problem, cognitive impairment, emotional distress, lack of motivation, refractory to treatment, side effects of medication
- Provider tensions: various recovery competencies, inefficient knowledge transformation, pressure, tension, frustrated, low motivation, inadequate colleague support, negative belief towards serious mental illness.

Resulting from these tensions is the prominence of the medical model and risk adverse environments which contribute to ongoing segregation, obstruction and passivity, and low engagement. The process framework developed allocates competencies according to each of these tensions for in-patient recovery oriented practice including:

- Engaging with in-patients to reduce tensions (environmental, personal and provider tensions, and build relationships)
- Providing individually tailored services
- Fostering recovery (hope, empowerment, skills, readiness, network, advocacy)
- Ensuring continuity of recovery process[77].

Russinova et al. (2011) empirically validated a set of conceptually based recovery oriented competencies from the perspectives of mental health consumers, peer workers and providers. This work highlights the crucial role of workers in maximising recovery using particular strategies and attitudes that acknowledge consumers as people (not an illness), and encourage hopefulness and empowerment. This study informed the development of an instrument to measure workers recovery-promoting competence and provides guidelines for improving recovery focus in services.

[76] NHS Education for Scotland (2010)

[77] Chen et al. (2013)

Interestingly, an investigation of community mental health nurse perspectives of recovery oriented practice in the UK (n=23) and course documentary analysis found that there is a gap in what these nurses were taught and their perspectives on their ability and confidence in recovery oriented practice. That is, while nurses reported high confidence in their understanding and ability to apply recovery oriented practice, only one course document used the term 'recovery model'[78].

Finally, Kraus et al. (2012) involved a cross sectional study with case managers from community mental health centres (n=114) to investigate professional burnout, job satisfaction, beliefs about recovery oriented services and contribution of demographics and structure of services. The finding was that regardless of demographics and reported job structures, case managers who reported their agency as having higher levels of recovery orientation also had lower levels of depersonalisation and emotional exhaustion/burnout and higher levels of job satisfaction. This established that there is an important relationship between perceptions of the recovery-orientation of services and staff members' own sense of wellbeing.

[78] Gale and Mashall-Lucette (2012)

4. Conclusion

Considerable progress has been made regarding understanding recovery and implementing a recovery oriented approach to practice. The results of the current review indicate that there has been an increase in empirical and systematic studies and frameworks or guides since the original literature review conducted in 2009. However, while the evidence underpinning recovery and recovery oriented practice has grown, the core of recovery and the critical components of recovery oriented practice appear to have remained consistent.

Further support has been found regarding the difference between personal and clinical recovery, and the importance of seeing a consumer as an 'expert' and fostering their independence and autonomy. The qualitative and value driven aspects of the relationship with the service provider are central, and include the fostering of mutual respect, collaboration approach, hope, optimism, innovation, goal achievement, and social connection. The importance of language and culture has been emphasised. In addition, recovery oriented practice requires a person centred and strengths based focus, including sensitivity to how a consumer defines their experience, self-identity and sense of community and culture. Workers must collaborate with consumers and recognise that every person's pathway to recovery is unique. A whole of person, whole of life approach must be taken that allows for flexible responsiveness according to fluctuating needs determined by the consumer. A critical factor to supporting recovery also includes maximising social inclusion and community connectedness, and partnerships with carers and other support people. Ultimately, consumers must be treated as equal human beings who, like anyone else, want a life that is meaningful and allows them to contribute and connect in the way that they choose.

Overall, the findings of the current literature review also continue to support the underpinning constructs of the ROSSAT Tools, including the importance of:

1. Relationships
2. Respectful practice
3. Consumer self-directed focus
4. Belief in consumers recovery
5. Obtaining and sharing knowledge and information, and
6. Participation and social inclusion.

These constructs are discussed in more detail below.

Relationships

The literature since 2009 provides substantial evidence to support the notion that "*recovery begins when you find someone or something to relate to*" (Slade 2010). Findings also support the critical importance of relationships and social support to a person's recovery, including relationships with workers, family, friends, peers and the community.

In addition, 'connectedness' was one of the five recovery processes identified in the empirically based conceptual model of personal recovery developed by Leamy et al. (2011), and the theme of connection and reconnection emerged in many studies. New evidence also indicates that the further a person progresses along their recovery journey, the more likely they are to want to establish a diversity of friendships, feel needed and valued by others and come to terms with family relationships.

Finally, evidence suggests that personal recovery does not necessarily require treatment or interventions by service providers, and that while workers can be critical to the facilitation of a recovery process they are also able to hinder this process.

Respectful Practice

A strong emphasis on the need for recovery to remain anchored to the human rights movement from which it originated continues in the literature. Similarly, respect for and responsiveness to diversity is deemed critical as recovery is different for everyone, according to their unique experiences and context. To deliver recovery oriented practice staff must have the knowledge, skills and attitudes required to be holistic and responsive to age, culture, physical health, alcohol and other drug use, gender, and sexual orientation among other factors.

Studies since 2009 have explored recovery in relation to specific populations or factors and many differences have been highlighted. However, many similarities have also been identified including the need for:

- Respect for individuality, personal interpretations and personal histories
- Support for self-directed care and empowerment
- Strengths based person-centred care
- Being culturally responsive
- Attending to overall health and wellbeing and the social determinants of health
- Overcoming stigma, discrimination and systems of oppression and privilege
- Respectful language that supports hope and possibility
- Involving people as active agents in their own recovery

- Being inclusive of family, community and relevant others
- Connecting people with communities and meaningful activities
- Spirituality and meaning in life
- The importance of identity (whether seeking, revising or maintaining)
- Providing safety, trustworthiness and choice.

Consumer Self-Directed Focus

Consistent with findings in 2009, the premise that recovery is best guided by the person with lived experience remains supported, as does the shift of seeing a person with lived experience as a person with expertise instead of a patient. In particular, a growing evidence base supports the difference between clinical and personal recovery and highlights the importance of respecting the consumer voice and their view on their own recovery. Related to this is support for the importance of personal responsibility and self-management, and the recognition that recovery belongs to each individual. Empowerment is also a key theme, for example as the fifth recovery process identified in the empirically based conceptual model of personal recovery developed by Leamy et al. (2011) which emphasises personal responsibility, control over life and building on strengths. The evidence suggests that the provision of support for consumers to take control and self-direct their own recovery journey is still a gap in every day practice.

The importance of flexibility and tailoring services to the level of need is also supported in the literature. Evidence continues to suggest that recovery is a non-linear process and as such different types of support will be required at different stages along a continuum. Goal setting is also impacted on by this continuum, where people in later stages of recovery tend to set more ‘approach goals’ and hold ‘broader life roles’.

Belief in Consumers’ Recovery

The evidence is resoundingly clear that recovery (both clinical and personal) is possible, and in fact it is more likely that people will grow on a recovery journey than not. There is also substantial evidence to suggest that hope is critical to recovery and that fostering hope is a key role of a worker. Specifically, hope and optimism are the second recovery process in the empirically based conceptual model of personal recovery developed by Leamy et al. (2011) which may involve belief in recovery, motivation to change, and having dreams. Later stages may also involve acceptance of illness and more control over symptoms. In addition, the literature supports the use of a strengths based approach and a focus on empowerment, including a lesser focus on risk aversion and a shift away from a deficit model.

Obtaining and Sharing Knowledge and Information

A number of studies and guides pointed to the importance of providing information and options to consumers, to support shared decision making and self-directed care. It is also important to support processes like assessments, action planning, and joint planning for crisis management. While this topic was only explicitly mentioned in a small number of studies, it is implicit in many more. It is only through understanding personal recovery, and having sufficient knowledge about recovery, that a worker will be able to support a person's recovery journey and impart this information to them.

Participation and Social Inclusion

Finally, there is substantial evidence to support the importance of inclusion and participation in social and meaningful activities for facilitating recovery. Specifically community participation, the opportunity for work and one's environment can either facilitate or hinder recovery and people must overcome social barriers such as negativity and stigma in order to engage in the community. Research demonstrates that those who have higher participation activity also have higher recovery, quality of life and meaning of life and that people in their later stages of recovery will be more likely do things for and experience pleasure, to contribute through meaningful activity, to hold broader life roles and be taking up opportunities to work. Meaning in life is the fourth process identified in the empirically based conceptual model of personal recovery developed by Leamy et al. (2011). The importance of people participating in the design and delivery of services has also been consistently highlighted.

In summary, this review suggests that the ROSSAT does continue to reflect current evidence, however a number of small gaps have been identified, including:

- Recognition of diversity, especially Aboriginal and Torres Strait Islander people
- Trauma informed care and practice
- Physical health.

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