Recovery in Mental Health: Global Perspectives

Shine the Light for Someone's Journey

This art reminds us that hope is available to everyone in the world and we all should be part of the light that shines out for others.

Cover Art by Lived Experience Contributor, Martha Hopkins

To enquire about the original art, please contact: jrmh@ontarioshores.ca
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Recovery in Mental Health: Global Perspectives

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Welcome to the Inaugural Issue

Mamdani, Karim

Ontario Shores Centre For Mental Health Sciences

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KEYWORDS
Recovery, Mental Health

As President and Chief Executive Officer of the Ontario Shores Centre for Mental Health Sciences (Ontario Shores), I am delighted to see our vision as a recovery focused mental health sciences centre further realized through this new scholarly publication.

We are delighted to publish this first issue of the Journal of Recovery in Mental Health. We launched this journal because we believe there is a need for a platform that covers the wide scope of international recovery focused mental health care and includes both the professional and lived experience perspective.

As the papers included in this first full issue of the Journal of Recovery in Mental Health demonstrate, mental health and recovery-oriented practice are global issues. I am excited to see this journal established to further connect us as an international community of mental health service providers and to inspire and inform our individual and collective efforts to achieve and sustain exemplary recovery oriented care environments.

We are supported by an excellent editorial advisory board who bring expertise, collaboration and creativity to their work. I hope you enjoy the first issue of this journal and I look forward to sharing this ongoing journey with you.

Karim Mamdani
President and Chief Executive Officer
Ontario Shores Centre for Mental Health Sciences
Editorial

Global Perspectives of Recovery and Mental Health

Arbour, Simone

Ontario Shores Centre for Mental Health Sciences

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KEYWORDS
Recovery, Mental Health, Canada

“Participation and inclusion do not involve changing people to fit in, but changing the world.”

I am very honoured to be the first managing editor of this important publication. This journal will serve as a forum of learning and discussion about our ongoing understanding of recovery from mental illness. I would also gratefully like to acknowledge the support of our publisher, Ontario Shores Centre for Mental Health Sciences. The establishment of this journal further realizes the organization's commitment to its vision of advancing both recovery-related research and practice. Those who benefit from this initiative stretch beyond the walls of the hospital and will likely include mental health professionals and service users alike both in Canada and abroad.

With these ambitions in mind, it is my pleasure to introduce our first themed issue of the journal, Recovery in Mental Health: Global Perspectives. Mental health systems, service delivery, and ultimately recovery potential are dependent on so many factors tied to the economic, social, political, and cultural contexts. The goal of this issue to provide a snapshot of a variety of mental healthcare landscapes across the globe, to share, and learn from the innovations of others in transforming systems and service delivery to optimize practice and the recovery environment.

Mental health is a global issue. Reports of the global burden of mental illness estimate the lifetime prevalence of mental health disorders to be anywhere from 18.1% - 36.1%. For those with serious mental illness, the prognosis from medical professionals at times can be pessimistic and bleak. This makes personal recovery and the integration of recovery-oriented practice into service delivery all the more important to support those
individuals to live beyond their diagnosis and to find hope and meaning, even despite their challenges and symptoms.

The recovery movement began decades ago when the world seemed so much bigger than it does today. But with the advances in technology, innovation, dissemination of research and knowledge translation, international collaboration has provided a number of opportunities to learn from one another’s successes and challenges in system transformation. International collaboration has also given us the opportunity to identify commonalities and differences in our understanding of personal recovery from mental illness and recovery-oriented practice implementation across nations and cultures.

**Recovery Research and Practice Around the Globe**

Although recovery-oriented practice guidelines have been launched in a number of national contexts, many have commented that organizational transformation has proven to be difficult. Canadian research regarding the challenges in implementing recovery-oriented practice outlines inconsistent staff training and the lack of adequate resources to fully realize implementation models as barriers preventing organizational transformation. Researchers in Ireland have also found that service provider knowledge about recovery has remained unchanged despite an increase in training and education. These findings suggest that, like individual recovery, understanding how to integrate and promote recovery-oriented practice is also a 'work in progress.'

The dissemination of research related to recovery and recovery-oriented practice is important because lessons learned across the globe help newly established recovery-related initiatives to anticipate and mitigate possible barriers and setbacks. I know this to be helpful, especially for my own work. In developing the Recovery College here at Ontario Shores, we greatly consulted the innovative work conducted in the recovery colleges in the United Kingdom, Australia, New Zealand, and the United States. These national mental healthcare landscapes were quite advanced in terms of offering co-designed recovery initiatives; and access to this international information filled an information gap within Canada where recovery colleges are quite new. This type of information is also important because healthcare funding is always stretched; and having access to evidenced-based, recovery-related research can assist in ensuring efficient and effective use of limited resources.

Recovery-related research and knowledge translation is the unifier that bridges gaps between countries and enables the establishment of a common language and foundation of understanding. Research is the means by which we can advance both recovery theory and recovery-oriented practice in order to influence system change.

Our journal is supported by an esteemed group of editorial advisory board members who also span the globe and include Dr. Larry Davidson, Director, Program for Recovery and Community Health School of Medicine and Institution for Social and Policy Studies Yale University, United States; Nicholas Watters, Knowledge Exchange Centre, Mental Health Commission of Canada; Dr. Lindsay Oades, Centre for Positive Psychology, University of Melbourne; Christine Holland Ontario Family Caregivers’ Advisory Network; Dr. Kwame McKenzie, University of Toronto and the Wellesley
Institute; Glenna Raymond, former champion of recovery at Ontario Shores; and Linda Gravel, Director of Quality at Mackenzie Health, Richmond Hill, Ontario, Canada.

In each themed issue, the journal will provide readers with the most current and innovative recovery-related research, policy development, debates, leading practices and perspectives. The Journal of Recovery in Mental Health highlights both the professional and lived experience perspectives to provide a comprehensive look at issues impacting the mental healthcare system and the individuals and groups who use its programs and services. We welcome submissions from mental health professionals, recovery advocates and those who are ‘experts by experience.’ Our lived experience editor shares his perspective in each issue. Individuals with lived experience with mental illness also contribute to the original artwork on the cover of each issue.

**Recovery in Mental Health: Global Perspectives**

In our first themed issue, *Recovery in Mental Health: Global Perspectives*, we are pleased to have submissions from across the globe. We have representation from North America, Europe, the United Kingdom, and Australia.

In our first article, Rickwood and Thomas provide an account of many recovery-related achievements in Australia. The authors suggest avenues requiring further attention, such as the development of the concept of recovery for adolescents and creation of recovery curriculum to incorporate into standard training for all mental healthcare professionals.

In the second article, authors from the Mental Health Commission of Canada provide an overview of some of the key initiatives undertaken since the Commission’s establishment a decade ago. Of particular note is the establishment of the *Canadian Guidelines for Recovery-Oriented Practice*. As the concept of recovery becomes more widely accepted in Canadian mental healthcare, these guidelines provide a practical means by which quality improvement initiatives and research into the recovery environment can take shape.

The third article is written from a blended professional and lived experience perspective. Korsbek outlines the irony and paradox that the Danish mental healthcare system of many years past actually afforded her the long-term supportive environment that fostered her recovery experience. She notes that, now that recovery is the national mental health initiative of Denmark, there appear to be barriers to care and the recovery experience.

In the fourth article, Rotheram et al. present a current status update on the evolution of the system transformation in England. Specifically, they describe the implementation of ‘Life Rooms,’ an innovative recovery-oriented service delivery model which connects the entire community and provides an inclusive and positive means of supporting individuals with mental health challenges, carers, and community members alike who want access to resources, education, and a positive environment.
In the fifth article, Thomas et al. provide a synopsis of the development of prudent health care in Wales. In addition, the authors describe the mission of Hafal, peer-led services for individuals with severe mental illness. In contrasting their work with the principles of prudent healthcare, the authors position recovery within a health economic model and demonstrate that user-led initiatives are cost-effective means of providing individuals with mental illness access to support and information that might otherwise be lacking.

Taken together, all the articles in this themed issue highlight that, although there may be some differences, there are indeed commonalities in passion for human rights and desire for improvement and system transformation. These articles also demonstrate that even though recovery philosophy and recovery-oriented practice may continue to be works in progress, we are making advances and are on a collective journey to identify and understand factors that promote recovery from serious mental illness.

Call for Papers
We are accepting submissions for our next themed issue regarding *Recovery Across the Lifespan*. Mental health has never been more relevant to so many different demographic groups, from adolescents and young adults to the adults in the sandwich generation as well as those who make up the geriatric population. Mental health challenges can occur regardless of age. We welcome manuscripts from authors representing a diverse range of recovery-related research, practice, ideas, and perspectives reflecting the diverse mental health needs of individuals of all ages. Such a collection can help to broaden our understanding of these needs in order to improve access to treatment across service areas and care transitions as adolescents become young adults or as the population ages. System improvements are needed so that gaps in care are minimized. The journey of recovery is not linear, nor is it a quick one. Research regarding recovery at different points across the lifespan may shed light on how this recovery journey can be enhanced.

We welcome your correspondence and submissions for the following themed issues.

1. Recovery Across the Lifespan, submissions due April 15, 2017
2. Recovery and Community Engagement, submissions due September 15, 2017
3. Recovery from Hospital to Community, submissions due December 15, 2017
4. Recovery and Co-Occurring Disorders, submissions due April 15, 2018
5. Recovery in Forensic Settings, submissions due September 15, 2018
6. Leading Practices in Recovery Colleges, submissions due December 15, 2018

References


Lived Experience Editorial

The Canadian Patient Perspective

Rose, Brian T.

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KEYWORDS
Recovery, Mental Health, Lived Experience, Canada

Introduction
The Canadian population is very compassionate when it comes to mental health awareness, but there is always room for improvement in terms of treatment and reintegration into society after an inpatient stay. Mental health professionals use research findings, look at other countries, and adapt new program ideas to improve the mental health experience.

One such program came out of Australia and Great Britain and is run completely by patients. I was involved in a study at Ontario Shores Centre for Mental Health Sciences (Ontario Shores) where patients were in charge of running their own groups from colouring groups to badminton. I developed a running group based on an article I found in the newspaper that talked about a running program. For my group, I believe the fact that I was a peer benefited the others, but the group was mostly comprised of males which may have been a deterrent for some. To help address this, a female Occupational Therapist helped guide the group, becoming a great addition and making the group more inclusive for female patients. In the beginning, some units were excluded due to physical or mobility barriers, but it was later decided that even those in wheelchairs could be involved if we pushed them. The program expanded to include all units in the hospital.

Following this experience, Ontario Shores launched a Recovery College. The entire program was built on the premise that peers and staff would work together, run programs, and offer education as a means of empowering patients and promoting recovery. Seeing their peers develop programs was a way to encourage others’ involvement; and the lived experience made the program relatable to the patients.

I am a part of a Patient Advocacy group at Ontario Shores, and we discuss topics about what new mental health hospitals are like in other countries. We have had opportunities to discuss hospital design and what makes a great living space for a patient. We learned that in Liverpool, England, patients could access beautiful courtyards as a
means of enhancing their environment. This prompted us to question why our courtyards were locked and only open for special events. This only permitted them to be used for a couple hours a month. The advocacy group worked to raise quality treatment issues within the hospital and to increase awareness of the mental health movement in the community. There was discussion of inviting the local community to Ontario Shores; and we explored having our own outdoor ice rink. Being located right on the shores of Lake Ontario, an outdoor skating rink might have been challenged by weather, and although many topics were discussed within the group, no decisions were made on the ideas. We also discussed a community that had many concerns about a new mental health hospital being opened in their community. When the local community came to see the new hospital, it looked like the lobby of an airport, beautiful and inviting, this helped break down the stigma associated with hospitalization.

Therapeutic Programs

Peer support is a growing practice among health care providers. At Ontario Shores, there is a team of peer support specialists that have endured their own difficulties. Sharing their journey with patients is one way they assist in the recovery process, both their own and that of the patient. This is effective as patients can relate to peer support workers; they feel they can share their stories in a non-judgmental environment. It was a peer support worker who asked me if I would be the host of ceremonies at an education celebration. This gentleman let me know it was the start of something big in my life and that it would cause a ripple effect. I have now given several speeches about my mental illness and my lived experience. That is what peer support is to me: sharing my lived experience to help others relate, and giving strength and hope to people on their own journey and at different stages of their recovery.

Therapeutic recreation also played a significant role in my recovery as I had opportunities to exercise, swim, play competitive sports with my peers, and participate in social activities. Recreational activities help take patients' focus off their illnesses and do something productive and fun. Most Canadians love hockey and embrace the winter. Ontario Shores rented the ice rink in the local community to allow patients the chance to skate or play hockey. This was a particularly special opportunity for those who have never skated and those patients who were new to Canada. When I was at a Northern Ontario hospital, we had the opportunity to make ice for the skating rink. I was a part of a team of patients and staff that would clean the ice of snow and debris every morning. We would use shovels and snow blowers to remove the snow, and then flood the ice with a fire hose which gave it a crystal clean look ideal for skating. At Ontario Shores, we had the opportunity to play floor hockey with both patients and staff on Monday nights. There was generally a huge turn-out which demonstrated its popularity with patients and staff. There is also badminton, basketball, bowling, weight rooms, cardio equipment and a therapeutic heated swimming pool that is unfortunately now closed due to budget constraints. The hospital now rents a pool in the local community to give patients the opportunity to swim.
Vocational services also helped me significantly to reintegrate to the community as they assisted me in writing a structured résumé. This assistance allowed me to find employment as I prepared to return to the community.

**Physical Environment**

Ontario Shores was designed so that patients' rooms were taken into consideration as most rooms face Lake Ontario. In the new mental health movement, recovery is a major theme in patients' day-to-day living, and the living conditions are a key component of that. For example, there are gazebos by the lake, rock gardens, vegetable gardens, apple trees, and flowerbeds to provide the most therapeutic environment possible. There are walking trails by the lake at Ontario Shores and the atmosphere is very calming. Although the hospital is modern, some areas are dimly lit. For example, some of the community living areas that face east do not get sunlight for most of the day. This was brought up in discussion groups where patients’ voices can be heard and improvements could be made as a result. In Liverpool and Australia, some of the modern mental health hospitals use special lighting and natural light which facilitate a supportive patient environment. For the most part, rooms at Ontario Shores are single bedrooms that face the lake, but other rooms are shared. A new hospital in Liverpool was designed so that all their rooms were single rooms. It has been suggested that the violence rates decrease when the living conditions for patients improve. Our group discussed how the nursing stations in Australia had no glass barrier, which made the nursing station look like an airport lobby. At Ontario Shores, patients call the nursing station 'the fish bowl' because it is an enclosure that is behind glass with a door or a slotted window that has to be open to get the nurses’ attention. A new unit at Ontario Shores has been operating for a year with an open nursing station model and hopefully this practice will be extended to other units.

**My Reality**

The mental health system can be hard to navigate. I was untreated in my home community for six months as my family and I were unable to find the help we needed. Unfortunately, with mental illness, as your symptoms worsen, people tend to pull away. With a diagnosis of cancer, people tend to become supportive and available as the illness worsens but, because mental illness is unseen, people have trouble relating and understanding the experience. Thankfully, modern medication has played a major role in my recovery. I have schizophrenia; and, although the medication works well, there are side effects including weight gain, headache, anxiety, lightheadedness, and insomnia. But when considering the positive and negative aspects, I would rather have trouble sleeping than experience major auditory hallucinations. I try tolerance as much as I can with my medication options, and I am on a monthly intramuscular antipsychotic injection. This injection is quite painful as it is injected in my gluteal muscle, tearing the tissue. However, the alternative is the deltoid muscle which is equally as painful. In addition, I also deal with depression and I am on a daily antidepressant. This medication increases serotonin levels which improves my mood. There are some holistic medications available for natural alternatives. My psychiatrist mentioned that to reduce
the cost and discomfort of monthly injections, some European countries are trialing a 3-month injection for my current prescribed anti-psychotic and that there is already a 3-month injection of similar medication available in Canada.

I have learned that it is very hard to work your way out of a mental health system, but it is possible. I have now been sober from poly-substances and alcohol for four years, and I am managing my illness with help. I seek resources in the hospital and in the community. I have committed my time to advocating for the mental health movement and endeavour to live a life that is balanced. I often use mindfulness techniques to self-calm and regulate feelings. Furthermore, I have been fortunate enough to have several of my stories about recovery published at Ontario Shores, on social media, and also in newspaper publications in my hometown. It is important to communicate about mental illness to the community at large in the hope of reducing the stigma that is often experienced by individuals diagnosed with a mental disorder. Although everyone’s journey may be different, what remains the same about the Canadian perspective is the caring and compassion we share for each other.

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Recovery and Mental Health Care in Australia – A Time of Change

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KEYWORDS
Recovery, Mental Health, Health Policy, Australia

Policy
Recovery has been acknowledged in Australian mental health care policy since 1992, in which time there have been four five-year National Mental Health Plans; and consultation is currently underway for the fifth. In the federated Australian government system, these Plans outline the shared responsibilities of the Federal and State/Territory governments in the implementation of mental health policy and the provision of services. The primary purpose of the original Plan in 1992 was to restructure mental health services into mainstream health care and progress deinstitutionalization in favour of community-based service delivery.¹ The second Plan incorporated a focus on health promotion, illness prevention, and early intervention.² Notably, the word ‘recovery’ was not evident in the first two Plans, but its essence was emerging with acknowledgement of mental health promotion as “action to maximize mental health and well-being” for both the general population and people with mental illness.³

The term ‘recovery’ was first included in the third Plan and was defined according to William Anthony as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability.”⁴ In 2004, Rickwood argued that recovery was being implemented in Australia, “slowly but surely”.³ The current consultation draft for the Fifth National Mental Health Plan is underpinned by five values, one of which is recovery: “There should be a focus on recovery and enhancing wellbeing, including by recognizing each person’s potential to live a fulfilling life and contribute to their own recovery”.⁵

Action
To aid policy implementation, National Standards for Mental Health Services were released in 1996, initially as voluntary standards, and revised in 2010 to reflect changes in the delivery and focus of mental health services.⁶ These were augmented by National Practice Standards for the Mental Health Workforce 2013, which outline expected

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capabilities for mental health professionals, complementing discipline-specific practice competencies for the professions of psychology, psychiatry, nursing, social work and occupational therapy. These documents articulate the principles and practices of recovery-oriented mental health services. Service providers have reported that the Standards have increased prominence of recovery principles, providing an impetus to focus on good quality clinical care for each person, and noting that these improvements were driven by collaboration with service users.

To add impetus to the National Mental Health Plans, a National Action Plan on Mental Health was put in place from 2006 to 2011, aiming to build a more collaborative and integrated mental health system. Coordination between government and private services was emphasized, and service delivery was expanded to include providers of housing, vocational, educational, and community services. A component of better integration was a continuum of care approach for people seriously affected by mental illness: mental health services can be broadly categorized as community-based, residential, and acute; and people need to be able to move between these services as their mental health status changes. Recovery has been implemented at different rates and in different ways across this continuum of care.

Within the community setting, recovery-focused care increasingly has become a main priority. Collaborative care has been implemented in many community-based settings; for example, through the Collaborative Recovery Model, which is a comprehensive collaborative care framework promoting a strengths and values approach that has been adopted by many non-government service providers in most Australian jurisdictions. Shared management and self-directed services have emerged in the community setting, with some services providing individualized funds for clients, resulting in practical and psychological benefits for service users from being able to use the funds in ways they felt would be personally most beneficial. Partners in Recovery is a federally funded, community-based recovery-focused program that provides support facilitators for service users, to assist in the coordination of care and integration of services around individual client needs. A final report of an external evaluation of the Partners in Recovery program is currently with the Federal Government; the evaluators concluded that the “initiative has assisted participants in areas such as housing security, physical health, psychological support, and social connection, and there is significant evidence the program has created positive outcomes in a range of domains for individuals.” Peer support programs with a strong recovery focus have also developed within the community sector, enabling people who have a lived experience of a mental illness to encourage and mentor other community members.

At the acute end of the continuum of care, while some inpatient facilities have adopted a recovery orientation, this has been much slower and far less pervasive than for the community sector. It requires a significant shift in the model of care that is provided, and implementation can be challenging for staff. One initiative that has been instigated in some adult inpatient units is the creation of family rooms, providing a fun and intimate space for parents to spend quality time with their children when they come to visit, rather than the previous arrangements of visits being in the foyer or garden. Feedback from
parents and staff indicated the rooms demonstrated to parents that their role as a parent and their relationship with their family was important. Other inpatient units have restructured their delivery of services in response to a movement toward delivering mental health services within mainstream health services. One former psychiatric hospital that became a general hospital offering mental health inpatient care, implemented a comprehensive health care approach and a recovery orientation model of care. The new general hospital service allowed for a more diverse skillset of nursing care, including mental health and registered nurses. However, these arrangements brought new challenges whereby the nursing staff found the staffing changes and new workforce flexibility resulted in a diversification of roles, competition over the delivery and content of care, and some nurses reporting heavy workloads under the new system.

Inpatient services face a range of barriers to adopting a recovery orientation. The lack of comprehensive recovery-based nursing training within undergraduate curricula has been identified as a key area of concern, with university programs needing to ensure that their nursing students gain the necessary skills and attributes required to provide recovery-based care in the inpatient setting. Nurses in recovery-oriented settings are very aware of their frontline role in supporting clients in their recovery, using a range of attributes and approaches to assist people in their care, including the incorporation of storytelling, safeguarding, treatment, and responsibility for recovery into their approach. A further challenge to the implementation of a recovery orientation within inpatient facilities is the design and aesthetics of the facilities. Design is an essential component in assisting people to feel safe in their environment and to feel that they have access to staff and to amenities.

If a recovery paradigm is to be fully implemented within the inpatient mental health system, then care for service users must be aligned with their cultural background, yet this remains a challenge. To date, there has been little research into how the mental health system meets the needs of Aboriginal and Torres Strait Islander Australians and, in particular, concerns have been raised of how current acute services provide a safe and culturally sensitive environment for Aboriginal and Torres Strait Islander women. Women, in general, admitted to inpatient units in Australia have expressed a need for hospital units to understand how difficult it is to live in the hospital and that women need to be involved in meaningful activities while they are there.

A relatively new addition to the mental health service continuum are residential services offering tailored support and care for people with sub-acute symptoms. These services are generally operated by non-government organizations and provide support in a community-based residential setting, with a focus on opportunities for clients to learn daily living skills, symptom management strategies and develop community connections. These services may accept admissions from current inpatients, as a transitional step in preparing to return to community living (step-down), and also from people receiving care in the community who need additional support at a time when their symptoms may be escalating, as an alternative to a hospital admission (step-up). The services prioritize recovery-based care and psychosocial rehabilitation founded on key principles of recovery that promote hopefulness, personal empowerment, social connectedness, self-determination, and global
well-being. Residential services encourage a collaborative decision-making approach in setting recovery goals, emphasize the development of social connections, assist clients to develop strategies to manage their symptoms, and foster positive mental health. An emerging research base shows that such community-based residential services are an important part of the continuum of care, comprising a valuable support in the recovery journey.25

**Conceptualization and Measurement of Recovery**

A common challenge for recovery-based services in all settings across the continuum of care is the many different understandings of recovery,26 and this lack of shared meaning and clarity can result in uncertainty for people accessing services. The primary ongoing tension in definition was well-articulated by Slade, Amering and Oades who argued that ‘clinical recovery’ is a perspective that comes from the medical model, which focuses on symptom reduction, functioning, and sustained remission, and is ascertained in a way that is invariant across individuals;10 whereas ‘personal recovery’ describes the perspective from consumer narratives, emphasizing living a satisfying, hopeful, and contributing life even with limitations caused by the illness, and in a way that varies across individuals. Many argue that the medical model approach still dominates in terms of what is evidence of recovery, particularly of effective service delivery;27 and multiple interpretations of personal recovery and how to implement such an approach abound. For example, some mental health workers interpret recovery as adopting a ‘hands off’ approach, rather than forging a collaborative relationship with their clients.28

A critical current issue is, therefore, how to measure recovery, including both outcome measures of personal recovery and how to determine whether services are implementing a recovery-oriented approach. Outcome measures of service users’ recovery is a complex and much debated field. Australia’s *National Mental Health Strategy* has promoted the collection of both outcomes and casemix data as a means of monitoring the quality, effectiveness, and efficiency of services. Since 2003, the *Australian Mental Health Outcomes and Classification Network* (AMHOCN) has reviewed, collated, and reported on outcome data at a national level and undertaken a training and service development role.29 All public sector mental health services across Australia now routinely report outcomes and casemix data, and this is being expanded to the community and non-government sectors.

A review of outcome measures in Australian community mental health organizations, completed in 2013, revealed at least 136 different measures in use.30 These were across seven domains, categorized as: recovery, cognition and emotion, functioning (activities of daily living and interpersonal relationships), social inclusion, quality of life, experience of service provision, and multidimensional measures.

Measures in the domain of cognition and emotion, where 40 measures were listed, and the functioning domain, where there were 18 measures, constitute those typically used as clinical outcome measures, many of which are relevant to clinical recovery. Of interest, the AMHOCN has recently undertaken a further review of functioning measures alone, identifying 20 measures for use with adults in specialized mental health services.
Investment in this review may reflect a growing focus on functioning as an outcome of particular interest to those evaluating and funding services.\(^{31}\)

In the recovery domain, which was defined as “the personal process of individual recovery”, 25 measures were identified in the AMHOCN review.\(^{30}\) The earliest measure was published in 1995 and 19 were developed in the United States. The large number of measures highlights the diversity of views regarding the components of personal recovery. A systematic review of recovery measures similarly found 22 instruments that measured the recovery of individuals but also identified 11 that assessed the recovery orientation of services or providers.\(^{32}\) Williams undertook a systematic review of measures specifically developed to assess the recovery orientation of services.\(^{33}\) They concluded that comparisons between the measures were compromised by the very different conceptualizations of recovery that were applied and variation in the organizational level at which services were assessed. Clearly, much work still needs to be done to determine appropriate measures of recovery, but both aspects are essential to assess: individuals’ experiences of personal recovery must be a focus for routine outcome monitoring in service provision and as a service evaluation indicator; and measures of the recovery orientation of services are essential process indicators for program evaluation and quality improvement.

A new measure was developed under the *Fourth National Mental Health Plan* to address its first priority area of ‘social inclusion and recovery’. This was in response to calls from consumers and carers for national measures that were better aligned with recovery concepts.\(^{34}\) The *Living in the Community* measure is a self-report instrument that asks consumers about recovery-related aspects of life, such as social activities, and work and study. It takes a holistic approach with a focus on indicators of social inclusion. Notably, this measure mentions the lifestage of youth and includes aspects relevant to young people from the age of 16 years. However, it has not been widely implemented to date.

**Young People and Early Intervention**

A critical issue for the recovery field is the lack of attention that has been given to what recovery means for young people and for those in the earlier stages of mental illness. Almost all the recovery literature, recovery-relevant research, and the recovery measures that have been developed derive from an adult focus, and generally from a focus on those with well-established mental ill health. Yet, in Australia there has been significant attention on youth mental health and early intervention, particularly targeting those aged 12 to 25 years.\(^{35}\) This is in response to recognition that this is the time of life when most mental illnesses first emerge,\(^{36}\) and when there are major barriers to engagement with professional mental health care.\(^{37}\) The language of recovery is not a good fit for services to young people (or children), and child and youth services are at risk of being marginalized in current mental health reforms if the fundamental value of recovery is not translated appropriately for these sectors.

There are many reasons why recovery is incongruous for younger people, as well as for those with emerging mental illness. Young people are in a period of constant change and growth, so the notion of recovering to a previous state is not relevant. While the concept of
personal recovery means transformation rather than returning to a previous state.\textsuperscript{38} The term itself still implies recovery of something that was previously lost. Moreover, young people, fortunately, should not have a history of damaging and traumatic service use, which many people with long-term lived experience have a need to recover from. If the Australian mental health strategy has been at all effective, then recent and current generations of service users should not be negatively impacted by the mental health system itself, in the way that people have been in the past.

One of the few attempts to consider a recovery framework in the context of young people is a discussion paper funded by the NSW Ministry of Health.\textsuperscript{39} Overall, recovery and recovery-oriented practice were reported to be consistent with the principles of appropriate care for young people with mental health problems; but it was argued that special consideration was needed to ensure that such principles are implemented in ways that are developmentally and contextually appropriate, and that recovery concepts needed to be discussed in youth-friendly language. The paper concludes that the CHIME conceptualization of recovery, which incorporates the processes of connectedness, hope, and optimism about the future, identity, meaning, and empowerment and purpose, is relevant for young people, but that how these are expressed depends on age and developmental stage. It may be that the language needs to be reframed within a child, young people and early intervention context.

Of special consideration, young people have unique needs regarding awareness of their mental health status.\textsuperscript{40} Child and adolescent services very often prioritize a strength-based approach and avoid diagnostic labelling, which may be unreliable and inaccurate, and can be unduly stigmatizing and limiting of future options. Identity development is a central concern for adolescents, and awareness and acceptance of mental ill health needs to be handled in a sensitive and developmentally appropriate way. Opportunities and positive growth must be the emphasis for young people, rather than a focus on accommodating and moving beyond the limitations of illness.

Recent Reforms
Most recently in Australia, the Federal Government has acted in response to a major review of the mental health system undertaken by the National Mental Health Commission—\textit{Report of the National Review of Mental Health Programmes and Services}.\textsuperscript{41} While this review mentions recovery in several places, its strongest focus is on providing ‘person-centred care’, which means matching available resources to identified need.

A fundamental restructure of mental health service delivery has ensued. Key features of this include the provision of many mental health care services through 31 Primary Health Networks (PHNs), which are expected to be responsive to the needs of their local regions across Australia, and accountable to the Federal Government for the planning and commissioning of services. Alongside this, a stepped care approach has been initiated, which aims to match the level of service delivery received to the level of need for an individual, with an emphasis on self-help, digital mental health interventions and low intensity services for people without severe mental illness.\textsuperscript{42}
Australia has also initiated a National Disability Insurance Scheme (NDIS), which aims to provide individualized support to people with disabilities. The Scheme is expected to enable an integrated service delivery approach for people with psychosocial disability as a result of mental ill health, through access to funding for the coordinated delivery of eligible services. In general, in the disability sector, the Scheme is seen as a positive approach to person-centred support.

However, the eligibility requirement of permanent, or likely to be permanent, impairment is thought by many in the mental health sector to be ‘toxic’. An expectation of permanence is incompatible with a recovery orientation, and also lacks recognition of the often fluctuating nature of symptoms and functioning for people with recurring mental illness. Further, the Scheme locks out many younger people and those earlier in the developmental trajectory of mental illness—people with more unreliable diagnoses and prognoses. Notably, ineligibility rates for applicants with mental illness have been shown to be significantly higher than those from people with physical, intellectual and sensory disabilities in the pilot sites, and a number of major challenges have become evident, including apparent inequities between jurisdictions in access rates.

Since mid-2016, the NDIS is being rolled out more widely across Australia, beyond the initial pilot sites. Over time, participants in other major Federal Government schemes, such as the Partners in Recovery program, will be required to transition into the NDIS.

Recovery in a Time of Change

How the underpinning value of recovery is realized through this rapidly changing environment remains to be seen. There is a considerable way to go before the NDIS is shown to be effective at meeting the needs of people with mental ill health across the continuum of care, and how it can operate in a way that embraces and facilitates a focus on recovery, while providing timely, responsive, and ongoing support. Primary Health Networks will need to demonstrate how they prioritize a recovery orientation in their planning and commissioning. Where accountability sits and how outcomes are determined in this more regionalized, person-centred and hopefully more efficient system, requires clarification.

It has been argued that embedding a recovery focus throughout the mental health system is achieved through consumer leadership, although Happell and Roper caution that improving services must be the responsibility of all leaders, not solely consumer leaders. The central consumer movement values of empowerment, equity, and self-determination are fundamental to a recovery-oriented system, and consumer leadership has the expressed purpose of driving systemic-level change. Such leadership needs to be clearly evident within the PHNs and its scope expanded to represent the broad range of mental health service users.

Australia has decades of well-intentioned strategy and planning, and recovery is a concept that is woven throughout its many policies and plans, at a national and also at many jurisdictional levels. Current national reforms are substantial and comprise more than well-
meaning words; it is a time of change. How a personal recovery orientation fares with these changes, and particularly how person-centred care is transacted within a recovery framework, is unknown. Through national leadership but regional integration, the reforms aim to create a more responsive system that matches the type and level of care to individual needs. Careful monitoring is required to ensure that the reforms truly do improve the quality of care as it is perceived by service users and their families, across the entire spectrum of mental ill health and continuum of mental health care services.

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Canada’s Journey to Recovery – A National Reflection

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KEYWORDS
Recovery, Mental Health, Canada

Introduction
Long before recovery became a national policy issue, people with lived experience were advocating for a system that provided hope, treated people with dignity and respect, and supported everyone in finding their path to better mental health and well-being.¹ The Mental Health Commission of Canada refers to ‘recovery’ in mental health as living a satisfying, hopeful, and contributing life, even when a person may be experiencing symptoms of a mental health problem or illness.¹, ² To operate in a recovery-oriented system means seeing people who are living with mental health problems and illnesses as more than their diagnosis, and instead, as individuals who are able to make their own decisions, direct their care, and manage their mental health and well-being.

Canada has made significant strides towards embracing and implementing recovery-oriented mental health policies and practice over the past decade.¹ In Canada, healthcare sits predominantly within the provincial responsibility with partial funding and some policy directions coming from the federal level. It is important to note that independent of federal involvement, provinces and advocacy groups have been working on the recovery agenda for many years. This article will provide an overview of the progression of recovery-oriented policies specifically within the federal Canadian landscape.

Origins of Recovery
At its core, mental health recovery is founded in the principles of human rights and civil liberties which arose in the Civil Rights movements of the 1960s and 1970s.¹ The concept of mental health ‘recovery’ emerged in the 1980s and 1990s in Canada and was championed by people with lived experience.¹ At its inception, recovery was seen as a radical concept at a time when people living with mental illness faced significant stigma, discrimination, and had very little decision making power when it came to their care. However, through the continued efforts of consumer-survivors and advocacy

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groups, the service sector began to slowly shift its mentality to embrace the recovery perspective. Throughout the 1990s and early 2000s, recovery was debated and discussed by practitioners and policy-makers. Some provinces and regions began to implement recovery-oriented practice, while other groups continued to oppose it. In 1998, the main national organizations representing community mental health, health professionals, and persons with mental illness, their families, and caregivers came together as a coalition called the Canadian Alliance on Mental Illness and Mental Health (CAMIMH). This was the first time health care providers, the community mental health sector, and people with lived experience sat together at the same table to develop a shared vision and set of values for transforming how we see mental health in Canada. While recovery was not explicitly referenced, the set of shared values opened with the underpinnings of recovery principles. These included ending discrimination against people living with mental illnesses, believing in people’s capacity to help themselves and each other, and acknowledging that a person’s own positive mental health is a resource for living with a mental illness.

In the spring of 2006, the landmark report by the Standing Senate Committee on Social Affairs, Science and Technology Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada was released. This report provided a call to action to create the Mental Health Commission of Canada with the mandate to develop a national mental health strategy, formally bringing mental health and recovery into the federal political landscape. Notably, the report identified recovery as the central, guiding principle for mental health stating that “it believes recovery to be the primary goal around which the mental health delivery system should be organized.”

The Mental Health Commission of Canada
In response to the call to action from Out of the Shadows at Last, the Mental Health Commission of Canada was created in 2007. One of the first actions of the Commission was the publication of Toward Recovery and Wellbeing: A Framework for a Mental Health Strategy for Canada in 2009. As noted in its title, this document identified recovery as a foundational framework for Canada’s national mental health strategy and formed the vision of a recovery-oriented health care system. For the next three years, the Commission undertook extensive national consultations based on this Framework to develop its national strategy.

Changing Directions, Changing Lives: A Mental Health Strategy for Canada was published in 2012, re-affirming recovery as a key focus. Fostering recovery and well-being was identified as one of the six strategic directions in Canada’s first national mental health strategy. This strategic direction laid the groundwork for the Commission’s ‘Recovery Initiative’ to help accelerate the movement to adopt recovery-oriented practice in Canada. The recovery initiative contained several activities to achieve this goal including identifying and consulting with recovery champions from the psychiatric community, professional groups, national and provincial levels. The recovery initiative’s key deliverables included developing a declaration towards recovery, creating an inventory of recovery programs, policies and research, and launching The Guidelines for Recovery-Oriented Practice.
Released in 2015, the Guidelines for Recovery-Oriented Practice were written to provide a comprehensive Canadian reference document for understanding recovery and to promote a consistent application of recovery principles. At the time of the release, while the concept of recovery had become more widely accepted, service providers were still struggling to answer the question, “What does a recovery orientation look like in actual practice?” The Guidelines seek to respond to this question. Divided into six dimensions, (Figure 1), the Guidelines break down the core principles and key capabilities including values, knowledge, skills, and behaviours for recovery-oriented practitioners and service providers.

Figure 1: Six dimensions of recovery-oriented practice

**Recovery Today and into the Future**

Today, in collaboration with its many partners, the Commission continues to advocate for a recovery-oriented mental health system and to promote the adoption of the Guidelines through its various recovery initiatives. Once a controversial concept, recovery has been shown to have positive impacts on clinical outcomes and has become widely embraced by mental health practitioners, service providers, and policy makers in Canada and around the world. We can see this in the many policies and mental health strategies put forward, in Canada and abroad, which include recovery as a core principle.

While some crucial steps in the right direction have been made, a lot of work remains to be done to achieve a recovery-oriented system that empowers people’s choices and self-determination, and which is welcoming and free of stigma and discrimination. Working with stakeholders and champions across the country, the Mental Health Commission of Canada believes that a transformed, recovery-oriented mental health system can be achieved.

Working together, recovery is possible.

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How to Recover? Recovery in Denmark: A Work in Progress

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Introduction

Twenty-five years ago, I was admitted into the Danish Mental Health Care System for the first time. Nobody talked about recovery, and nobody expected me to be where I am today. This was back in 1991, a few years after the emergence of the findings from the first long-term follow-up study of Harding et al., and two years before William Anthony introduced the concept of recovery as the guiding vision of the Mental Health Service System in the 1990s, today a publication of almost iconic status.

But these things were mostly discussed in narrow scientific circles, and generally 'over there'. Nothing of it had reached Danish mental health practice, as the time of my first admission was also 10 years before the concept of recovery hit the shores of Denmark from both sides of the surrounding sea - from Sweden on the one side of the coast and from the U.K. and U.S. on the other.

The next years of my life were difficult. All too easily, I internalized the image of a person with a severe psychiatric diagnosis that the system and the professionals, either directly or indirectly, communicated to me; and I was engulfed in the stigma of the outside world. I have always been good at adapting to ambient influences, and it was not an advantage for me when it came to maintaining my own identity and a non-broken self-image.

Nevertheless, the ability to adapt might be, to a certain extent, an advantage. By reading the system's expectations, I was, in time, able to turn, modify, and redesign the expectations more and more and put myself increasingly into the driver's seat, thereby propelling a recovery process that the system ended up not only supporting, but also encouraging, and, even in times of crisis, to ensure and maintain.

The years to come as a patient therefore became easier. Although I was often hospitalized for a very long time, I also completed my university education during the hospitalizations. I could more or less come and go as I needed, and I had an incredibly stable primary contact among the staff.

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She was there all along and was extremely adept in reading me. She knew very precisely when the limit was reached and I needed to be hospitalized. She often arranged my admission directly, bypassing the emergency visit and all administrative procedures. At the same time, she also very clearly saw all my strengths and resources and respectfully recognized my needs and preferences, including my need for self-determination and of exercising influence on my own treatment.

In fact, she followed me from almost the first admission and right up to the day I - after being a distinctive user (i.e. what at that time would be termed a rather 'chronic' patient) of the mental health services for ten years - left the system altogether, ready for proceeding with treatment with a psychiatrist practicing outside the statutory mental health treatment services.

In many ways, the system in fact ended up being fairly recovery-oriented, without ever having heard of the term.

**The Paradox of the Mental Health Landscape Today**

Today, we in the mental health care of Denmark have all heard of recovery; but the mental health system has, in the same period of 25 years, changed radically. Nowadays, almost no one using the mental health services, except in forensic psychiatry, is hospitalized for a long period. Very few people have the same primary contact among staff members for several years. It is almost impossible to be hospitalized without an emergency visit and triggering the legal procedures when in a crisis situation. For staff, it can be difficult to get to know the individual patients well enough to ensure the patient's autonomy and influence. The staff is generally very occupied with, among many other system-driven things, the documenting of their services, and rarely is there time for much in-depth dialogue with the patients.

There are, however, many ongoing recovery-oriented projects in the Danish mental health and a national campaign addressing stigma and self-stigma has been around for several years. But often the initiatives are time-limited or conducted as research, and Denmark does not yet, as is the case in some other countries, have an overall strategy on recovery in mental health.

At the same time, some of the ongoing recovery-oriented projects in the Danish mental health care systems remind me of some of the methods and approaches that were, to a greater or lesser degree - because sometimes, indeed, they were very much dependent on the culture and management of each unit - inscribed in the system I met in the 1990s. The overall landscape of mental health in Denmark today therefore sometimes looks a bit like a paradox.

If there is a paradox, it is, however, hardly a paradox only to be observed in the mental health system of Denmark. Instead, it is perhaps the paradox par excellence, the master paradox, which we, at this time of modern mental health care history, are caught up in and must face. From an optimistic angle, it might just be one of the bumps along the way of the work in progress to transform the mental health care services into a fully recovery-oriented mental health care practice; and probably there is one central reason for the paradox.
As part of the process of relieving people with mental health issues, their relatives, and the mental health care providers of the chronicity paradigm which has dominated our thinking on mental illness throughout much of the 20th century, we have had very good cause to be quite systematic in the deinstitutionalizing of our service settings. But time and time again we have forgotten, and still forget, or perhaps want to forget, that recovery does not follow a master plan or the organizing structures of any mental health services system, and that services must therefore be available and able to re-engage with people whenever needed in order to support their recovery processes.

The aspect of the inpatient mental health service settings that helped to facilitate my recovery was, especially in the beginning, also an obstacle to it. And this is what the paradox of inpatient treatment looks like at the individual level. On the one hand, there is the risk of engulfment, and thereby of the constructing of an illness identity that can be very hard to deconstruct. However, on the other, there is an essential need for most people with severe mental health issues to have a stable and often long-lasting and caring framework for a process of recovery to take place.

As it really takes time to find a way in the system, when struggling not to be engulfed, and it also takes time to find a way out of the system again, long-term inpatient treatment is not, in itself, a solution. But as it also takes time for each individual person who uses mental health services and for the providers of the services to meet and find ways together to make a road to recovery visible and possible, a very short engagement with a caring system is not always a solution either.

When Recovery Came to Denmark

In Denmark, the introduction of the concept of recovery coincided with the start of the new millennium. It was presented by the national Knowledge Centre for Social Psychiatry and mediated through a reception and translation of the work of the Swedish-based psychologist, Alain Topor.

The concept was immediately put on the political agenda and an initiative to set up a pilot on recovery in Denmark was approved by the Danish parliament in 2001, resulting in the publication of a state of the art report and then the initiation of a three-year project on recovery.

The project was undertaken by the national mental health NGO Bedre Psykiatri (Improving Mental Health Care) and The National Association of former and current mental health users (LAP). It resulted in two central Danish publications. The first publication, Recovery på dansk (“Recovery in Danish”), disseminated and discussed the international research of, and experiences with, recovery, and linked this knowledge to the Danish reality and practice. The second was the publication of En helt anden hjælp (“A completely different aid”) that was based on qualitative interviews with a total of 55 respondents from across the country and is still a pioneering first empirical study of recovery in Denmark.

The mental health system in Denmark consists of two different and separate service sectors. On the one hand, there is a regional health sector, which is geographically organized into five administrative sections and responsible for the mental health
treatment services, i.e. for all the mental health hospitals and for the outpatient community mental health care. And, on the other hand, there is a social psychiatry service that is driven by the 98 municipalities of Denmark existing within the five regions and responsible for the social support of people with mental health problems, including rehabilitation, education, and employment.

In the beginning of the millennium, the new knowledge of recovery in mental health was primarily discussed within social psychiatry. In 2005, when it was also introduced into the mental health treatment services by a few psychiatrists that had looked abroad and into the international literature on recovery, it caused a subsequent fierce debate in the leading Danish Journal of Medicine between different psychiatrists, with some of the participants in the debate declaring recovery a nearly sectarian pseudo concept with no scientific substance. Several years went by before recovery was more seriously put on the agenda in the mental health treatment services and gradually became part of the visions and policies of these helping systems.

The Adoption of the Recovery Vision: The Case of the Mental Health Services of the Capital Region

In 2011, the first policy paper declaring recovery a central vision of the mental health treatment services in Denmark was conceived. It was conceived in the mental health services of the Capital Region of Denmark, as a starting point for providing a more recovery-oriented mental health care practice.

In 2012, to further support the new vision of recovery-oriented mental health treatment services, an ambitious two-day conference was organized, which featured Patricia Deegan as one of its keynote speakers. Patricia Deegan published her first paper on recovery in 1988 and has since been a leader, instilling hope for many people with lived experience. She has been an advocate for recovery and has succeeded in introducing recovery to the mental health agenda in many countries around the world.

In 2004, Deegan had also been the keynote speaker at a conference arranged by the earlier three-year project on recovery in Denmark. But in 2012, the conference was also attended by many mental health providers of the treatment services and by senior management teams who, in their communication throughout the organization, had stressed the importance of the conference and made it clear that it should be given priority.

Since then, the mental health services of the Capital Region have worked towards implementing the recovery concept and turning it into a driving force for the development of the services. The region has launched a central strategy of involving consumers in the mental health services, focusing on certain areas of action and combining the areas of action with strategic goals and ways to attain them; and it has established a broad range of projects and activities on recovery and recovery-oriented mental health practice.

One of the first systematic initiatives of the mental health services of the Capital Region was to ensure that the vision of recovery was heard and understood throughout the organization. Within a year over 2013-2014, all 4500 employees in
the treatment services of the region were taught recovery and recovery-oriented practice by teaching teams consisting of both professionals and people with lived experiences. This was an initiative that subsequently resulted in the establishment of the first recovery college in the region, the first of its kind in Denmark.

By defining recovery not as a necessary clinical outcome, but by basing recovery on the definition of William Anthony as a personal journey, the Capital Region has asserted its willingness to take the lead among the mental health treatment services of the five regions in Denmark. As a consequence, one of the main goals in the treatment services of the Capital Region has been to ensure that the personal recovery goals of each person using the services are integrated into the treatment plans, and then, by following the nothing about us without us statement, to make sure that the person in treatment is present as a partner in the meetings of the treatment team in the services’ units.

Peer support was also a central initiative from the very outset. A pilot project in 2013-2014 that involved the hiring of people with lived experiences as peer-support staff members in six inpatient mental health treatment units of the Capital Region rapidly evolved into peer support being an integrated part of all the mental health treatment centres of the region, so that today there are peer workers in nearly every inpatient mental health unit. At the same time, the region has worked systematically to ensure consumer participation at an organizational level, and people with lived experience are now members of all central decision boards of the region alongside providers, professionals, and management.

In all this, the Capital Region has looked very much towards the U.K., i.e. the work conducted by the Centre for Mental Health in London, and by ImROC (Implementing Recovery through Organisational Change). This has entailed, for example, basing the recovery college of the region on the concept of co-production and on the principles of recovery colleges in general, as they are formulated in a briefing paper by ImROC. 

Today, the mental health services of the Capital Region are just about to start a new recovery initiative with the aim of consolidating and further implementing the existing initiatives and activities and to develop the recovery strategy for the coming years. It is expected that recovery, in the years to come, will be brought closer to the operating activities of the region and that the effects of interventions will, to a wider extent, be based on what people using the services consider meaningful and important.

**Danish Research into Recovery: Sporadic and Driven by a Few Enthusiasts**

While recovery has been central to the development and provision of mental health in Denmark, at least in some parts of the social psychiatry services and in some settings of the mental health treatment services, Danish research into recovery as part of these developments has been somewhat neglected. Recovery was, to some degree, put on the central political agenda by a national strategy for research into mental health in 2015; nevertheless, research into recovery is in Denmark scattered and mostly driven by a few researchers with a special interest in interventions and practices to support a recovery-oriented mental health practice.
Some of this can be explained by the great competition for the very limited research funds in mental health, and with existing research groups in other areas of interest, including biological and genetic research, which, on the grounds of many years of research, has a stronger research profile to receive the funds. But partly, it can also be attributed to the fact that recovery is not yet understood as a real field of research, but rather it is viewed as a development initiative.

Although it is increasingly recognizing that individuals’ personal recovery goals and preferences have to be a part of mental health practice, research into interventions in mental health still focuses primarily on traditional clinical outcomes such as symptoms and functioning. In addition, a culture of involving people with lived experiences in identifying, designing, producing, and distributing research has not yet, or not very particularly, reached mental health research in Denmark.

Some of the current intervention research projects in Denmark, which in the international literature on recovery are classified as specific recovery-oriented interventions in mental health, are research projects in illness management and recovery, in individual placement and support, and in shared decision making. Some other Danish research initiatives related to recovery in mental health involve, research on patient-controlled hospital admissions, recovery in inpatient mental health care, and peer support.

Perspectives and Challenges: Peer Support, Tokenism and a Work in Progress

Peer support is sometimes seen as the single most important factor contributing to changes towards more recovery-oriented services, and peer support is a rapidly evolving practice in Denmark in both the mental health treatment settings and in mental health in general. In 2014, Denmark also established a national network of peer workers. It is a network that has already attracted many members and is expected to increasingly affect the agenda within the landscape of mental health.

However, as in most other countries with peer workers in mental health, peer support is also a practice meeting several challenges and sometimes also a practice to be questioned. The challenges lie in the extent to which peer workers can optimize their practice in the actual treatment settings and how each peer worker perceives the meaning of peer support and exerts the role, as well as the extent to which peer workers are hired as only a symbolic manifestation of a recovery-oriented practice and expressing a politically correct tokenism.

Tokenism is a word used by Anderson and Deegan in their 1998 publication on how to include people with lived experiences on boards and committees in mental health. Tokenism, a practice of making only a perfunctory or symbolic effort to be inclusive to members of a group, can manifest itself when only one person is recruited to be a representative of all, or if one or several individuals recruited are those with positions and perspectives identical with, or close to, the prevailing understanding of the group.

The final perspective on recovery in Denmark must be on the concept of tokenism as it applies to the broader mental health mandate of a nation, because while some initiatives and practices of the recovery paradigm have in Denmark been highly
prioritized and, to a certain degree, been transferred into a form of new mainstream practice of mental health, other initiatives and practices are rather neglected.

Although this barely differs from what can be seen in many other countries, Denmark does not seem quite ready to integrate all perspectives on recovery in mental health. This, in particular, applies to the more activist parts of recovery in mental health, evolving from the long international history of civil rights movements, to the alternative understandings and approaches in mental health regarding medication, trauma and voice hearing that are often judged to be too different or too radical to be accepted.

At the same time, there are still great differences as to which degree each of the five regions in Denmark responsible for the mental health treatment services are embracing the concept of recovery and have made it a paradigm for the service delivery. The mental services of the Capital Region have certainly been at the forefront, while other regions are, to a greater or lesser extent, lagging somewhat behind or understand recovery in a different way, sometimes still as just another word for clinical remission.

Recovery, in Denmark, is a work in progress, and probably will be for a long time yet, as the question of how to recover is not only a question to be asked to the individual users of the services’ systems, but also to the systems themselves. To the service systems, it is a question of how to recover from a long history of paternalism and of viewing illnesses categorically, with very limited expectations for improvement, and of how to design services to fit individuals, and how to avoid services designed so that individuals must fit into them. And it is a question that also pertains to what is perhaps a paradox of today’s mental health agenda, as pointed out earlier in this paper.

Research has shown that a vast majority of providers in mental health have a fairly positive attitude towards the idea of recovery-oriented care, but that the actual application of recovery-oriented practice is challenged by the demands of an organizational system taking precedence over approaches that support personal recovery. People in recovery are still not in the driver’s seat when it comes to decide when, and how, to be helped. Although it is to a certain extent probably avoidable that a system is also system-driven, we must, in Denmark as in everywhere else, ask ourselves how much and how often we forget that recovery is not linear, does not follow a master plan, and is rarely attained within a short period of time.

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The Life Rooms: An Innovative Recovery Approach

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KEYWORDS

Recovery, Mental Health, United Kingdom, Delivery of Health Care

The National Context

Mental health care in England has developed significantly. In the early 19th century and into the Victorian era, asylums were established for those suffering from mental distress. These were set up as self-contained establishments in rural areas with a strong focus on work and recreation.

Moving into the 1950s and beyond, greater acknowledgement of human rights and the creation of the National Health Service (NHS) led to the closure of many Victorian asylums and the movement towards a community-focused model of mental health care.

Alongside this, the development of psychiatric drugs further secured the establishment of the medical model as the frame of reference for mental health workers. Both the International Classification of Disease (ICD) and the Diagnostic and Statistical Manual for Mental Disorder (DSM) are utilized in the United Kingdom; the clinical language of diagnosis, disease, and drug treatment remain the main references for statutory mental health services.

Within this picture, policy initiatives have aimed to increase the effectiveness of mental health services. For example, the Care Programme Approach was developed in the 1990s to provide more intensive, co-ordinated support to those who need it. More recently, in 2011, the British Coalition government published a mental health strategy that aimed to support people with mental distress through aiding their physical health, challenging stigma, and supporting those caring for people experiencing mental distress.

Despite this, mental health outcomes have still been worsening in recent years.¹ The current financial situation of the NHS warrants more creative approaches, exploring opportunities beyond what has already been tried.

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Mersey Care NHS Foundation Trust (Mersey Care) is a secondary mental health Trust, providing specialist mental health services in North West England and beyond. Mersey Care provides specialist inpatient and community mental health, learning disability services, addiction services, and acquired brain injury services.

Although Mersey Care primarily provides secondary mental health services, it is reasonable to ask broader questions about mental health support. For example, what is the effectiveness of mental health support for those being discharged from secondary mental health care? What are the needs and support for those being managed by primary care, or indeed those not receiving any formalized clinical service at all?

These broader questions are the motivation for one of Mersey Care's latest ventures: The Life Rooms. The Life Rooms explores the contributions that Mersey Care can make towards supporting the recovery journey of those moving out of its services. It also aspires to strengthen the opportunities for support at a primary care level, thereby reducing the time spent with General Practitioners (GPs). Furthermore, the opportunities available at the Life Rooms aspire to work preventatively with those who may not yet have sought formalized help for their distress. It is with these broader aspirations in mind, and against the backdrop of an increasingly stretched health care system, that Mersey Care developed the Life Rooms, a 'community hub' model in response to mental distress. This hub houses the Recovery College, volunteering services and employment support under one roof in an inclusive and positive environment.

Development of Life Rooms
The Five Year Forward View for Mental Health document sets out the start of a ten-year transformation for NHS mental health care, specifically:

- a shift towards prevention
- recognizing the goals of people outside their mental health diagnosis
- tackling the disproportionate way in which mental health problems affect those living with social deprivation

Within the business case for the Life Rooms, there is a strong focus on recovery. It states that recovery is built upon four key foundation stones:

- finding and maintaining hope
- re-establishment of a positive identity
- building a meaningful life
- taking responsibility and control

The broad theme running throughout this literature is transforming mental health care delivery and the specific recognition of community approaches within this:

"Leaders across the system must take decisive steps to break down barriers in the way services are provided to reshape how care is delivered."
The notion of recovery links with the prevention focus of the *Five Year Forward View for Mental Health* document and the recognition of people beyond their diagnosis. The goal to create a centre for recovery and social inclusion, designed to address the social determinants of mental distress, as detailed in the business case for the Life Rooms, is an attempt to respond to the need for a community offering that can provide a social support response.²

Within the literature, there is also recognition of the potential economic benefits of service transformation. Poor mental health costs £105 billion a year in England.¹ Projects such as the *Rotherham Social Prescribing Service* give clear, independently evaluated examples of where Localized Clinical Commissioning Groups (CCGs) have implemented social responses to mental health and evidenced their wellbeing outcomes and economic effectiveness.³⁴

**A New Approach: The Life Rooms**

The Life Rooms opened its doors on May 9, 2016 and has begun to work towards the aims and objectives outlined above. The Life Rooms houses Mersey Care’s Social Inclusion and Participation Team, which comprises a number of Mersey Care services including a Recovery College, volunteering services, and employment support. In addition, The Life Rooms offers a safe and welcoming environment with access to a library service, computers, and a café. The Life Rooms provides a confidential advice area in which vocational pathways advisors provide individual support and community partners offer information and guidance on issues such as housing and employment. In terms of raising the profile of mental wellbeing, the Life Rooms makes a statement by placing a mental health service in the heart of the community. The Life Rooms is offering a non-clinical space that is accessible by all members of the community, not just service users. The Life Rooms offers practical community resources, in addition to wellbeing support. This offers a new way of challenging stigma in the sense that it begins to demystify and provide some transparency to the concept of a 'mental health service.'

Promoting mental wellbeing through non-clinical opportunities aligns with the concept of 'social prescribing'. The Social Prescribing Network describes social prescribing and its potential in the following way:

> By facilitating the patients’ access to a whole range of voluntary and local services, including becoming volunteers themselves, there is much potential to nurture local social capital and catalyse health-creating communities that strengthen their ability to care for themselves and each other. Social prescribing recognizes that the third sector is a largely untapped asset that can deliver further integration between health and social care in the creation of a more responsive and efficient local health economy. Social prescribing can be used to empower the patient to look for solutions to social problems before a crisis occurs that might affect their physical or mental health.⁶
The Life Rooms offers a further contribution to the development of social prescribing in that it is operating within the framework of secondary mental health services. However, it also encompasses the need for the facilitation of third sector assets within the model. The Life Rooms brings together non-clinical opportunities for support, including those within the third sector, alongside local authority offerings, private sector workers, and Mersey Care’s own services. The bringing together of such a wide range of opportunities for advice, support, learning, and self-development within a non-clinical, community-facing environment is an innovative approach to wellbeing support.

Improving access to meaningful occupation or employment opportunities becomes particularly significant when we consider that the employment rate for adults with mental health problems in the United Kingdom remains unacceptably low: 43% of all people with mental health problems are in employment, compared to 74% of the general population and 65% of people with other health conditions.¹

Further, the recognition that meaningful activity is a key factor to recovery, as well as a strengthening factor for a community, informs one of the key aims for the Life Rooms. Employment is not appropriate for many people, but everybody should have the opportunity to explore what is meaningful activity for them.

Mersey Care has a significant history of holding service user and carer voices as central to service development via the provision of participation opportunities throughout the Trust. Central to Mersey Care’s approach to participation is a commitment to the rights of service users and carers to be involved as equal citizens in decisions that affect their lives by everything that we do. Service users and carers are not involved in Mersey Care because it will be good for them, good for the Trust, or because it is the policy flavour of the government of the day. Service users and carers are involved because they are valued citizens with a human right to be involved. Working in this way results in many benefits for the Trust, society and ultimately the individual:⁵

- Enabling service users and carers to participate as equal partners in all aspects of the Trust is an important way for Mersey Care to meet its legal obligation, to protect and promote the human rights of vulnerable people in its care.
- An essential component of quality service development and delivery is the lived experience service users and carers have of those services. Service users and carers also have a wide range of valuable knowledge, skills, and experience in addition to their knowledge and experience of Trust services.
- The participation of a diverse range of service users and carers who reflect the communities served by the Trust is essential if the Trust is to be a relevant and responsive organization.
- Participation of service users and carers as equal partners in decision making is a means of tackling the power imbalance that often exists between professionals and lay people and is a means of achieving cultural change.
• Participation of service users in decision making has good recovery and social inclusion outcomes for service users and carers, i.e., they move beyond an existence defined by illness to a life defined by themselves.

This ethos is central to the Life Rooms work. As such, there are many opportunities for participation within the Life Rooms, including service user steering groups and advisory panels. Volunteer services are also positioned within the Life Rooms, giving service users, carers, as well as the community opportunity to contribute towards Life Rooms service provision. Support is available to anyone interested in exploring volunteering opportunities within Mersey Care and beyond. There are a number of volunteers who work within the Life Rooms, all of whom are service user volunteers.

There are a number of opportunities to receive employment support in the Life Rooms. This can be provided by Mersey Care staff or external partners, or indeed, a combination of both depending on requirements. The Life Rooms facilitates support for individuals from a wide range of external organizations, as well as hosting events to showcase employers with appropriate employment opportunities.

The pathways advisor posts that have been developed as part of the Life Rooms service are key to this facilitation. They support visitors to navigate their way through the different Life Rooms offerings in accordance with their needs. They provide a point of contact for visitors, as well external organizations, and are therefore key to monitoring outcomes. The role is a brand new role within Mersey Care; in many ways it is similar to the social prescribing role outlined above. It offers the opportunity to work in a person-centred way with individuals as well as responding to community need via external provider offerings where necessary.

In terms of contributing to a stronger community through partnerships, the Life Rooms contributes to this agenda by forming partnerships with external organisations in order to create more effective service provision. The Life Rooms also provides resources for local community groups more generally. The library and computer access are examples of this, as well as hosting groups from the local Children’s Centre, local interest groups, craft, and book clubs. Additionally, since opening, the Life Rooms has hosted a number of events, offering wellbeing opportunities for those within Mersey Care and the local community.

Working in this way is particularly significant. It is not about financial input, but a community-focused, asset-based approach. The joining up of private, public, and voluntary sectors has potential to improve outcomes for individuals. Remodelling community services in this way also presents opportunities in a broader sense, creating potentially less expensive, more effective ways of working.

Finally, in recognition that people in marginalized groups are at greater risk of mental distress, promoting diversity and access to mental health support for marginalized groups is an important aim of the Life Rooms work. Evaluation of our client base in
respect of protected characteristics is on-going and will inform strategies within this area.

The Life Rooms: The Vision for the Future
As a service, the Life Rooms aims to contribute to the development of mental health services, prioritizing a community model. The Life Rooms explores the contributions that Mersey Care can make towards supporting the recovery journey of those moving out of its services. It also aspires to strengthen the opportunities for support at a primary care level, thereby reducing the time spent with GPs. Furthermore, the opportunities available at the Life Rooms aspire to work preventatively with those who may not yet have sought formalized help for their distress.

Current economic challenges faced by the United Kingdom Health system present mental health services with a considerable challenge. It is increasingly apparent that previously accepted models of community care are becoming unsustainable. It is also clear that demand for mental health services within the Trust is growing by between 4% to 5% each year. This reality challenges us to think differently around how we provide community care. The Life Rooms model seeks to respond to this challenge by taking a community asset-based approach involving cohesion between statutory, voluntary, and commercial sectors. Our aspiration is to develop an holistic social model that not only results in better outcomes for individuals and communities, but one that also enables us to switch off costs relating to traditional clinical models of care. A full econometric study will be required to robustly build the case in support of this aspiration. Looking ahead, a second Life Rooms site has been identified. This represents the start of the process of replicating the Life Rooms model across the Mersey Care footprint.

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References


Hafal: A Prudent Healthcare Approach to User-Led Service in Wales

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Hafal

Hafal, which means equal in Welsh, is the principal charitable organization in Wales working with individuals recovering from serious mental illness and their families. Hafal is managed by the people it supports; individuals with serious mental illness and their families. Hafal has over 350 staff and volunteers who together provide help to over 1,000 people affected by serious mental illnesses. This includes schizophrenia, bipolar disorder, and other diagnoses which typically involve psychosis or high levels of need that may also require hospital treatment. Hafal's mission is founded on the belief that people who have a direct experience of mental illness know best how services can be delivered and formulated. As a member-led organization, Hafal provides support across all seven Local Health Board areas of Wales and is dedicated to empowering people with serious mental illness and their families so they can achieve a better quality of life, fulfill their ambitions for recovery, fight discrimination, and enjoy equal access to health and social care, housing, income, education, and employment.

On December 1st 2016 Alun Thomas took on the role as new Chief Executive at Hafal, and he did so at an interesting time. In a verbal presentation to stakeholders he commented:

We now have a progressive Welsh mental health law and strategy in place, and patients and carers have gained key new rights in recent years. However, recent figures show that Health Boards in Wales have reduced spending on services; furthermore, a report published by a Welsh Assembly Committee in November 2016 raised serious concerns about services for young people. So while Wales has some
of the best mental health legislation and policy, there is evidently room for improvement in the resourcing and delivery of services.

What Can Hafal Do About it?
As a charity, Hafal's mission is simple: do everything we can to promote recovery from mental illness, either by delivering services directly to clients, or by campaigning for a better system experience for all patients and their carers. But while patients' recovery is the first and foremost aim, we also want to make an economic case for a recovery-based approach to resourcing and delivery of services. A recovery approach not only improves the lives of patients and their carers, it may also lead to significant savings in valuable mental healthcare funding.

Research evidence estimates that the cost of mental health problems in Wales is in excess of £7.2 billion per annum.\(^1\) In addition to this, people with a serious mental illness are at increased risk of developing specific physical illness. For example, they are at twice the risk of developing diabetes,\(^2\) they are three times more likely of dying of heart disease, and have a reduced life expectancy of up to 20 years.\(^3\) They are also more likely to experience what is referred to as 'unexplained' physical symptoms, caused by psychological distress which often goes unrecognized and unaddressed. Therefore, investment in mental health services also provides a realistic opportunity of seeing a reduction in physical health care budgets.

A Prudent Healthcare Approach
Wales has a devolved Government in Cardiff which has responsibility for planning, funding, and providing health and social care, independent of the United Kingdom Government in London. Pioneered by the Welsh Government, prudent healthcare is a term which is often used when discussing the future of healthcare in Wales. The main driver behind prudent healthcare in NHS Wales is not saving money but ensuring the people of Wales receive the best possible care from the available resources.\(^4\)

Four of the principles of the prudent healthcare approach are:

1. Achieve health and wellbeing with the public, patients, and professionals as equal partners through co-production.
2. Care for those with the greatest health need first, making the most effective use of all skills and resources.
3. Do only what is needed, no more, no less; and do no harm.
4. Reduce inappropriate variation using evidence-based practices consistently and transparently.

The aim and ethos of prudent healthcare are to promote services, which are as effective as possible at supporting recovery and to be as efficient as possible in achieving this. There is a need to look at the human cost and the financial cost when developing services. Those costs are not inversely proportionate: recovery-focused services with an emphasis on co-production may lead to better outcomes for patients and a reduction in financial cost.
Developing a service culture with a philosophy of recovery and aspiration, as opposed to one of stability and maintenance, means that people are supported to progress and move on instead of being maintained in their current condition and situation. Recovery means long-term savings; stability and maintenance means ongoing cost, both in human and financial terms.

In practice, Hafal believes a model of prudent healthcare for mental health services should focus on two principles. First, resources should be targeted efficiently in moving those patients receiving higher-end (and more expensive) services down into lower-level support services. This will have the greatest impact in terms of improving people’s lives and, additionally, in reducing the cost of their care and treatment. Second, services should provide the earliest possible intervention. One cannot prevent illnesses such as schizophrenia and bipolar disorder, which require high-level care; but by treating them at the earliest possible point, outcomes may be greatly improved for patients. It is possible to reduce the effects of long-term illness by altering the illness trajectory and drastically reduce care and treatment costs and the long-term detrimental effects of illnesses such as schizophrenia and bipolar disorder. Hafal believes that people can be equipped with the right self-management skills to take care of themselves in the long term. Any savings made by applying these principles should be reinvested in mental health so that services are sustainable and well-resourced for future generations.

Indeed, early intervention services have become a priority for Hafal. In 2013, a dedicated early intervention service called Up 4 It was launched for young people in Gwent in partnership with Aneurin Bevan University Health Board. This ensures that young people receive optimal care and treatment at the earliest stage of their illness. Sarah, a 23-year-old service user, told us: "If you get timely treatment when you first experience mental illness then you can be supported to stay in education or employment and prevent the illness from damaging the rest of your life." This project is specifically aimed at preventing hospital admission, which is costly, both for the patient in disrupting their life and for the NHS.

Hafal adheres to the prudent healthcare principles of targeting care for those with the highest needs; however, it is the case that many of our clients with a diagnosis of schizophrenia or bipolar disorder have found it difficult to access evidence-based psychological therapies. All too often service users report that they receive psychiatric treatment in the form of medication, with little information about the benefits of 'talk therapy.' To address this issue, a campaign was launched to ensure that evidence-based psychological therapies are included in their care plan. The impact has been significant. One carer told us: “Our son has responded hugely from receiving transactional analysis, and it has helped him take ownership of his illness. Earlier intervention would have been cost effective.”

In line with this work, Hafal recently launched Let’s Talk!, a Big Lottery-funded project, which aims to promote and raise awareness of evidence-based psychological therapies for people within Wales with a serious mental illness. The proposal for the Let’s Talk! project was developed in close consultation with HELP, Hafal’s Expert Leadership Panel. HELP is now a group of some fifteen people all of whom have lived experience of mental illness, and who use that experience to support Hafal’s campaigning, and to contribute to the development of better mental...
health services across Wales. Currently they are actively involved in mental health research, in peer mentoring and support, and in offering presentations and training to combat stigma and to inform professionals and the wider public. A number of HELP members have received psychological therapy and believe this intervention to be a major factor in their recovery. HELP is therefore very committed to improving access to psychological therapies for other people in a similar position.

Let’s Talk! About Psychological Therapies\(^6\) was launched at the Senedd (Welsh Government) on World Mental Health Day 2016, and has a number of innovative activities to promote access to evidence-based talking therapies. This includes establishing a Centre of Excellence Observatory for evidence-based psychological therapies which will provide, for the first time, a one-stop shop for information and advice for the general public and professionals seeking details of local and national service availability across all sectors, public, private, and voluntary.\(^6\)

**The Recovery Centre**

Over ten years ago, Hafal Members and Trustees formulated a vision for in-patient mental health services in Wales. The vision was to establish a hospital led by its service users; a progressive service with a strong recovery focus based on comprehensive care planning. It required an inviting, therapeutic, and home-like environment with high-quality bedrooms, ensuite facilities, and a wealth of activities on offer. Initially the vision was perceived as unattainable and radically removed from everyday reality. After ten years of development, thanks to the work and campaigning of Hafal Members and the financial support of Big Lottery and the Welsh Government, that vision has become a reality.

The new Gellinudd Recovery Centre in Pontardawe opened in January 2017. This Recovery Centre is the first of its kind in Wales and the UK: a user-led, not-for-profit in-patient service with a recovery ethos, delivered by a third sector organization. In developing the Centre, staff travelled to Canada and the USA to see models of best practice. Academic visitors from Japan and Taiwan have travelled to see the Centre.

The Centre has been developed in close liaison with the NHS in Wales to ensure the service provided fits with existing NHS services and meets the highest clinical governance standards. Its approach is strongly in line with Welsh law and policy including the *Mental Health (Wales) Measure* and the *Together for Health* which are Welsh Government strategies.\(^7\) The Centre is registered with Health Inspectorate Wales, and is on the NHS Framework.\(^8\) It is staffed by both registered mental health nurses and registered general nurses, and will be supported by physiotherapy, occupational therapy, psychological therapy psychiatrists, and, most importantly, by those with a lived experience of mental illness.

**Criminal Justice and Mental Health**

Undeniably, the likelihood of coming into contact with the criminal justice system is increased for people with mental illness. The expansion of the prison population in the last ten years coincides with significant increases in the proportion of inmates experiencing mental illness, substance misuse, or learning difficulties, to a point where nine out of ten prisoners in Wales experience these problems.\(^9\) In 2010 the National Audit Office estimated the cost to the UK economy of re-offending of those released from custody to be between £9 billion and £13.5 billion. An updated figure
of up to £15 billion is reflective of 2016 prices.\textsuperscript{10} Within any process of rehabilitation, however, maintaining bonds with family and friends is considered to be most significant towards success.\textsuperscript{11} In Wales, unfortunately, those subjected to imprisonment face additional barriers due to insufficient national custodial accommodation. Of the 4,679 people imprisoned in 2014 from a home address in Wales, over 2,000 were serving their sentence in England. Some categories of prisoner, such as women or young adults, have no such accommodation in Wales.\textsuperscript{12} Unfortunately, current figures reveal the highest number of prison suicides since records began with understaffed prison mental health teams struggling to help prisoners in desperate need.\textsuperscript{13}

Under the requirements of the \textit{Codes of Practice of the Police and Criminal Evidence Act 1984},\textsuperscript{14} Hafal provides an \textit{Appropriate Adults} safeguarding service, which requires the police when detaining or questioning mentally disordered or mentally vulnerable adults suspected of crime, to obtain the support of an appropriate adult to counter the risk of injustice within the legal process. These invaluable interactions with staff from Hafal, who are experienced in the field of mental health, have initiated a partnership approach with offender management staff and increased the numbers of people whose offending behaviour has been identified as symptomatic of an underlying mental health problem. In turn, this has led to a more appropriate jurisprudent healthcare approach where interventions now become more focused upon the previously unmet mental health needs of the offender.

In 2015 Hafal undertook a pilot scheme, operating within the South Wales Police area, to provide a holistic recovery model approach to address identified psycho-social issues contributing to the offender’s poor mental health and subsequent offending. Of 35 individuals supported via Hafal’s recovery model through the scheme, only two went on to receive custodial sentences while 33 were diverted away by practical socio-psychological support.\textsuperscript{15} This pilot has provided a springboard for Hafal’s current \textit{Out of the Blue Project}, which now takes referrals from the \textit{National Offender Management System} and is anticipated to support in excess of 200 offenders with existing mental health problems over a three-year period.

\textbf{Care and Treatment Plan}

One of the best opportunities for a prudent healthcare approach is the standard \textit{Care and Treatment Plan} prescribed by the \textit{Mental Health (Wales) Measure} which, since 2013, is Welsh law for all secondary mental health service users in Wales. The \textit{Plan} is a useful tool in that it empowers patients and carers to have their say in their care and treatment. It is goal focused, it records all needs in one place, and, importantly, it is holistic, covering all areas of life.\textsuperscript{15}

Health services are rarely commissioned on the basis of delivering outcomes valued by patients. Instead, many health services are arranged around the services and structures they already have, rather than the needs of those receiving healthcare.\textsuperscript{3, 4} By involving people in the process of planning their care and treatment and by identifying outcomes for that person in all areas of life, the \textit{Care and Treatment Plan} offers an opportunity to counter this tendency in health services, and provides a more patient-focused live service.
Furthermore, the Care and Treatment Plan facilitates a partnership between the people who use and provide services. The Plan promotes recovery, engaging people in planning their care and treatment and working as a goal-setting tool which jointly identifies a way towards better health.

**The Recovery/Cost Pathway**

How can Prudent Healthcare work in practice? Hafal has worked with a number of NHS and Local Authority partner commissioners around Wales to develop the Recovery/Cost Pathway which is an analysis of service costs and to an extent, an analysis of the impact on the service users' life. This analysis is illustrated in Figure 1, with approximate costings included.

![Diagram of the Recovery/Cost Pathway](image)

**Figure 1 Recovery Cost Pathway**

Hafal’s members know from personal experience that recovery-focused services supported by good quality Care and Treatment Plans help to foster several outcomes.

For example, the majority of users at Medium and In-patient secure level could move faster down to 24-hour care level and below which realizes a saving of £60-125,000 per person per annum. Most patients at 24-Hour Care level can move much more quickly than traditionally down through Specialist Service: Daytime Staff level to Peripatetic level, a saving of £43-57,000 per person per annum. Users at Peripatetic level can be prevented from relapsing and entering higher-level care. Many more users overall could reach Primary Care level rather than remain stuck at high levels. The No Services level which denotes full recovery, already achieved by many people who have experienced schizophrenia for example, can be a goal for many more users. In recent years, Hafal has been particularly successful in supporting clients to move from needing 24-Hour Care level, at a cost of approximately £65,000 per annum, to needing Peripatetic Care, at a cost of around £8,000.
The benefits for patients in terms of achieving a better quality of life have been vast. Specifically, Hafal has extensive experience of bringing people in high-cost private sector care back to local third sector service provision and has found that this more therapeutic, recovery-focused service leads to move-on to lower-level and lower-cost care, and improved outcomes for the client.

Real-Life Benefits
To really see the benefit of Prudent Healthcare\(^3\), you need to look at individual stories. Cath, who comes from Aberystwyth, was diagnosed with schizophrenia and spent 2 years in hospital from the age of 24; she then lived at home with her mother and was long-term unemployed. From 1996 to 2001, Cath was a tenant at Hafal’s Ystwyth supported accommodation project, which enabled her to move into her own flat and become more independent. By taking part in Hafal’s Recovery Program, Cath was able to set recovery goals and return to university to get a degree. She was also supported to take part in voluntary work and became Chair of the local Project Advisory Group. Taking Hafal’s recovery approach, Cath’s expectations were raised even further. When she moved on from the service she achieved one of her main recovery goals: to enter employment, becoming a Hafal Support Worker. She is now a Hafal Practice Leader managing high-needs supported accommodation service. In short the recovery process has empowered Cath to take control of her life, move on from services, achieve independence a good quality of life, and become a tax payer. This story is a perfect example of the Prudent Healthcare approach Hafal is employing. It shows how a progressive and ambitious program of support can empower a person to take steps towards recovery and reduce their dependence on services.

Hafal wants services in Wales to embrace this approach simply because it makes sense, in both human and financial terms. To this end, Hafal will continue to champion Prudent Healthcare, improved access to evidence-based psychological therapies, and the development of modern, innovative and effective services, designed for, and with, service users at the heart of developments.

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