Helping people towards recovery

Professor David Clark describes the skills, values, and knowledge that workers need to facilitate recovery in people seeking help for mental health problems. He points out that this research provides insights that can help improve treatment standards in our field.

After more than 50 Background Briefings, I turn my attention to how people overcome substance use problems. In particular, how do people who have become addicted to drugs and alcohol find the path to recovery?

I start by looking at research by Marguerite Schinkel and Nika Dorrer (2007) which was conducted to support the policy move in Scotland towards recovery-orientated practice in the mental health field. The project aimed to help the development of a recovery competencies framework for mental health workers in Scotland by obtaining the views of various stakeholder groups.

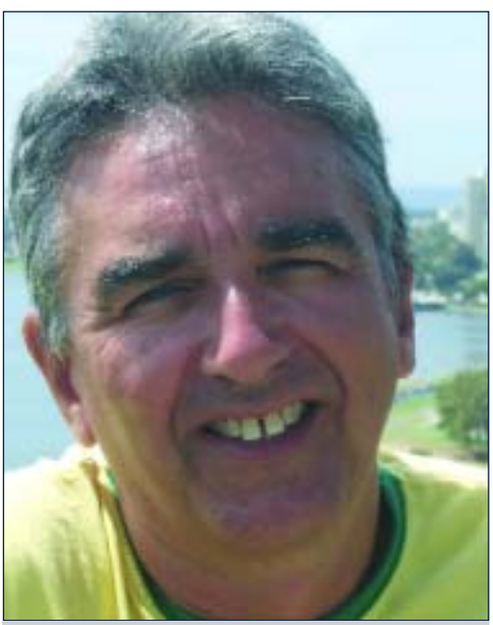
A number of the findings in this paper are just as relevant to how we need to view recovery in the substance misuse field. They also allow us to look at the skills, values, and knowledge that workers in our field need to facilitate recovery in people who present with a substance use problem.

Recovery as defined by service users in this study countered negative conceptions of mental illness that focus on deficits and deterioration. Recovery does not mean that people are necessarily symptom-free, but that they develop 'the ability to live well in the presence or absence of one's mental illness' (Mental Health Commission, 2001). Crucial to the concept is that recovery is an individual process, with the person themselves defining what living well means to them. Recovery is not an end-point, but an ongoing process of growth, discovery, and change.

In relation to our field, this approach indicates that a person does not need to be abstinent of substances to be in recovery. A person on methadone may consider himself to be in recovery because he has stopped using heroin and has an improved lifestyle. However, he may later change his mind and decide he wants to be completely drug-free, thereby starting on a new path to recovery.

The Schinkel and Dorrer (2007) research revealed that the basis for recovery-oriented practice was 'the ability to build up respectful relationships with service users, in which the worker has a genuine interest in the person, sees them as an individual, and takes them and their experiences seriously'.

Only in this relationship could trust be established. Service users also found it useful when workers shared something of themselves in the relationship, thereby acknowledging a shared humanity and overcoming of professional boundaries.



'...recovery is an individual process, with the person themselves defining what living well means to them. Recovery is not an end-point, but an ongoing process of growth, discovery, and change.'

Workers need to believe in and understand recovery, in order to be able to promote it. They have to understand that recovery is an individual process full of setbacks; it can take a very long time to achieve. They have to remain motivated despite this.

Recovery is promoted when mental health staff are good at listening, focus on people's strengths, and know when laughter may be an appropriate way to lighten the mood, create a bond in groups and help people to relax.

Service users felt that having a say in their care is vital to recovery. They need to be given more information, especially when they are first diagnosed, and where possible receive different options for treatment and support. Whenever possible, they should be allowed to take responsibility for their own choices and their negotiation of risk.

Carers felt that they are often marginalised and not sufficiently involved or kept informed by professionals. If the service user wants significant others to be involved, workers must share information and take carers' knowledge and experiences seriously.

The importance of balance and timing were two overarching themes. For example, a balance has to be found between creating safety and letting people take risks; between respecting service users' choices and decisions, and facilitating recovery through challenging service users' boundaries. There are no hard and fast rules in these areas; workers need to reflect on their practice to resolve these issues.

Study participants thought it was important that mental health workers have some experience of challenging life situations, are aware of their own mental health, and support each other in their work.

While some mental health training courses teach values that are in line with the recovery approach, none have an explicit focus on recovery. Most interviewees felt that such an explicit focus would be beneficial.

Participants considered the main obstacles to putting recovery competencies into practice to be overworked staff, a lack of time and resources, and a clash between idealistic training and existing work cultures. Finding respectful ways to overcome service users' lack of motivation also was considered to be difficult.

The researchers emphasised that recovery competencies can only play a small part in the implementation of a recovery approach. On the societal level stigma needs to be challenged, while on the service level the way mental health services are set up needs to be transformed. It was also noted that the attitudes of mental health workers have repeatedly been reported to constitute one of the main obstacles to the successful implementation of recovery-oriented interventions.

Marguerite Schinkel and Nika Dorrer (2007) Towards recovery competencies in Scotland: The views of key stakeholder groups. (Find on www.scottishrecovery.net site)